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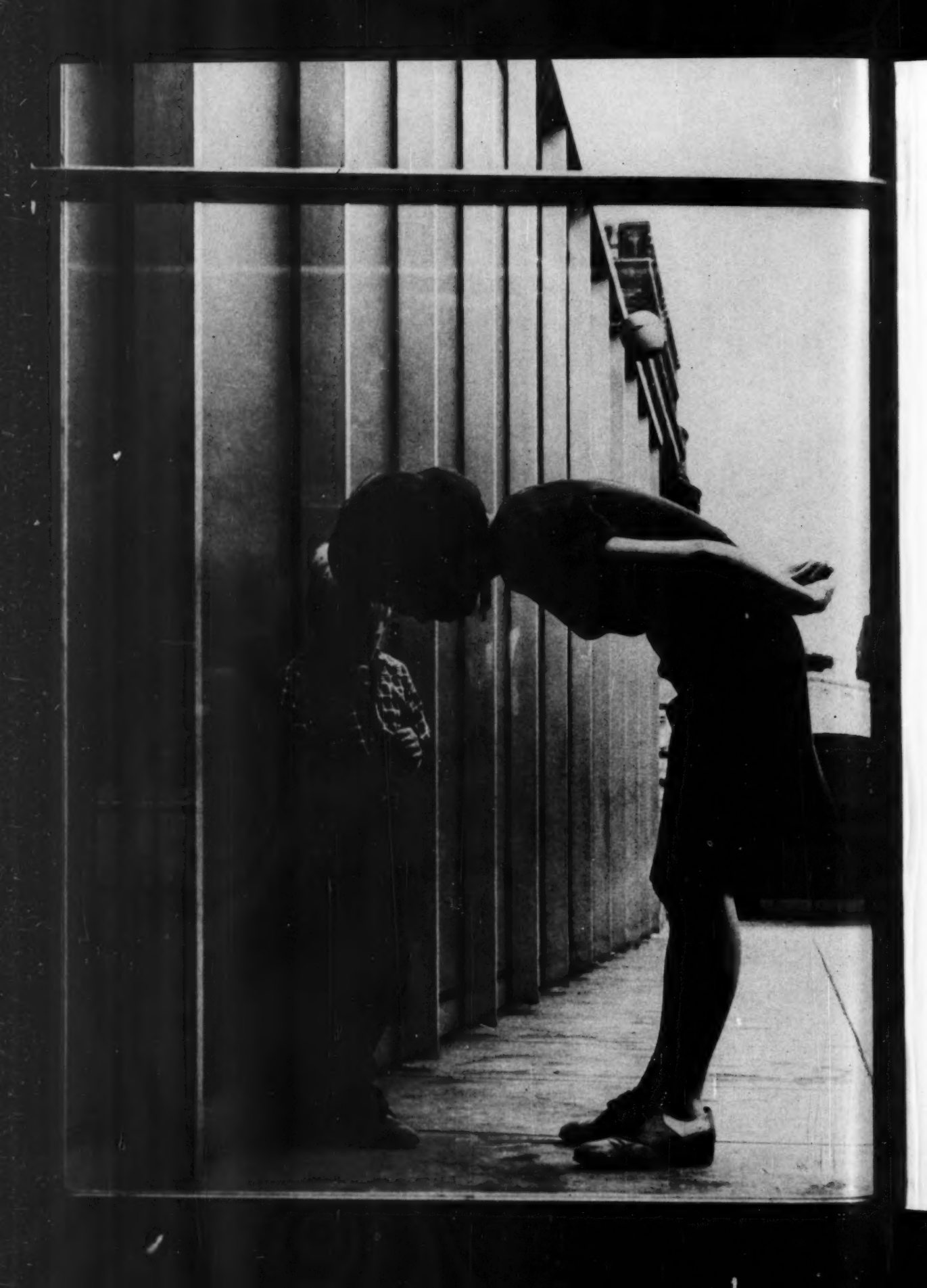

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Understanding a troubled child, as this teacher is obviously attempting to do, may be the first step toward helping the child overcome blocks to learning. How a psychiatrically oriented clinical team is working with groups of teachers to increase the understanding of both teachers and clinicians of the factors that affect children's performance and behavior in school is described in the article beginning on page 19.

children

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At first glance, few groups seem more dissimilar than the talented, privileged students who attend residential liberal arts colleges and the unwanted or neglected children who live in group residential centers. Yet behind the real differences in age and social privilege that separate these two groups, there are profound similarities in their situations. Essentially the same issues arise in planning for what one college dean calls "the care and feeding of college students" as in planning for the group residential care of children.

As Erving Goffman has pointed out, there are a few institutions in modern society that may encompass practically all aspects of a person's life. He calls these "total institutions,"[1] for in them residential life, social life, and work life are combined—often within the same walls, certainly within the same institutional framework. As examples he cites merchant ships, military services, mental hospitals, prisons, monasteries, and residential treatment institutions. He might also have cited institutions for neglected and dependent children.

This concept of "total institution" becomes more useful if we distinguish between different kinds of total institutions. There are three types: (1) those institutions that could be called *instrumental* because they are trying to get a job done in the outside world—for instance, a merchant ship carrying a cargo across the sea; (2) those institutions whose purpose is at least nominally *therapeutic*, preventative, or corrective, such as a prison or mental hospital; and (3) a small group of institutions whose explicit purpose is *developmental*, such as a residential college, a boarding school, or a residential center for neglected and dependent children.

A residential college, of course, is less "total" than an army or a prison: Students are on the whole free to enter and leave at will. But for most college students, during the academic year at least, their lives are embodied and to some extent regulated within a single framework and a set of walls. And obviously group residential centers for children are total institutions in the full sense of the word.

Developmental institutions, whether colleges or children's "homes," have a number of common characteristics. For one, they at least nominally accept as their primary objective the promotion of the "normal" or optimal development of their charges, the residents. They therefore usually try to ally themselves with what they take to be the natural forces for growth and development in the individual. They see their task as somehow stimulating, support-

COLLEGE STUDENTS AND CHILDREN IN developmental institutions

KENNETH KENISTON

ing, and confirming the development of each resident. In this respect they differ sharply from an instrumental institution like an army or a merchant ship, which may ignore or even impede the individual's overall development. And they also differ from therapeutic institutions like good mental hospitals, which have as a primary task to intervene and correct faulty development. This does not mean that developmental institutions like colleges or institutions for children do not have ways of correcting faulty development. But, on the whole, their goals are not so much to correct failures as to promote normal, healthy growth.

A second characteristic of developmental institutions is that they exercise quasi-familial functions. Ordinarily, such institutions arise in situations where families cannot or are thought not to be able to do an adequate job. A children's institution, for example, usually enters the picture when there is no family that can take care of the child, or when the child's actual family is exerting a destructive influence on his development. Boarding schools and residential colleges generally arise because individual families cannot provide the kind of "character-building," intellectual stimulation, or environmental enrichment provided by a residential school. This does not mean that developmental institutions should think of themselves as families, for they can never perform all the functions of a family.

Many of the same kinds of practical and theoretical problems arise in all developmental institutions, whether they are dealing with adolescents and young adults or with infants and young children. Some of these problems were underscored in two studies with which I have recently been involved. One of these was a study of "alienated" college students—a small group of students who were extreme in their rejection of what they took to be the dominant values and roles of institutions in American society. The second is an ongoing study of gifted students who drop out of college.

The psychology of alienation

For about 6 years, I was involved in the study of alienated undergraduates at Harvard University. The initial research consisted chiefly of objective tests—the systematic comparison of alienated and nonalienated students through the use of questionnaires. Almost 2,000 students were involved, but although these statistical studies yielded useful information, they did not take me very far toward the question I was trying to answer: Why is it that some students are alienated whereas others are not?

To try to answer this question I turned to a more intensive study of 12 students who had been selected because of the extreme degree of their alienation as measured by questionnaires. This group was contrasted with another group of the same size at the opposite pole—"extremely unalienated"—and with a third control group that was not extreme in either way. All three groups were studied over the last 3 years of their college careers.

Each student spent altogether about 200 hours par-

Based on a talk given at the Workshop on Group Residential Care of Infants and Young Children, New Haven, Conn., April 1966.

ticipating in the research. Each was interviewed about his views of the world, his current behavior, and his life history, and each took part in a large number of psychological experiments.

A comparison of the data from the alienated group with that from the other two groups revealed a number of distinctive patterns of ideology, behavior, life history, and fantasy among the alienated students. In addition to being alienated from American culture, they were on the whole pessimistic, distrustful, resentful, and cynical about human nature. They saw themselves as outsiders whose isolation and aloneness was part of the human condition, not their own personal problem. To them, the universe seemed a formless and unstructured chaos lacking in meaning and purpose. And they rejected all cooperative group endeavors on the grounds that conformity means the destruction of individuality.

Most of these students came from a similar family constellation. Characteristically, they described their mothers as magnetic, emotional, passionate, and attractive women to whom they, the sons, were extremely, often excessively, close. At the same time they described their mothers as possessive, confining, restrictive, nagging, and intrusive.

About their fathers, these alienated students volunteered very little information. When pressed to discuss their fathers, they described them as disappointed, frustrated, detached, outwardly cold men. However, the alienated students usually imagined that their fathers had, at one point in their own youth, possessed considerable imagination, idealism, and fire, which had been lost in adulthood. So the father, as the son saw him, was a man deeply disappointed by his own failure to realize his youthful dreams.

Such a family constellation, we felt, had obvious relationships to the development of alienation. Seeing their fathers as men who had been broken by life or by their marriages and thus defeated by "the American way of life," these students were determined not to let what happened to their fathers happen to them. In rejecting their fathers, they also felt it necessary to reject the society that, as they saw it, had ruined their fathers. In other words, from their fathers these students had derived an image of conventional masculine adulthood that was repugnant to them, so they spurned conventional adulthood in American society.[2]

In further explaining the alienation of these students, I should point out that Harvard undergraduates tend to be somewhat more alienated as seniors than as freshmen, although rarely to the extreme that these students reached. In addition, these students were on the whole an unusually imaginative, artistically oriented, and talented group of young men who argued that American society was in general not particularly hospitable to talented, creative persons. They were clearly reacting to the wider society as well as to their parents and family experiences.

Four major issues

When I discuss this material, I am often asked a number of related questions: Is alienation a kind of psychopathology? Why did the researchers not do more to cure these students of their alienation? Is it not a dreadful commentary on a college that its students become more alienated? Should the institution be doing something to change such students? Is alienation a good thing or a bad thing?

None of these questions can be answered simply. I mention them only because they point to two crucial issues that arise whenever we begin thinking about the development of a person in an institution:

1. *What is "normal" development?*

This first issue could be called the normative question—that is, the question of what kind of development the institution is trying to promote. Is the goal of a college, for example, to produce well-trained adults who will be able to fit smoothly into their positions in society? Or is it to promote critical intelligence and detachment from the immediate pressures and values of society? If we think that a smooth fit with society is the objective, then obviously any college that "alienates" its students from the prevailing society is a bad college. But if we think that critical intelligence and capacity for detachment from society is a good thing, then we may very well applaud a college that to some extent increases alienation in its students.

The normative question almost inevitably arises when one begins thinking about or planning an institutional framework that will encourage the "normal development" of the individual. Indeed, the terms "normal development" and "the optimal development of each individual" can be dangerous phrases since they may obscure the underlying value questions involved. We know that individuals can be stimulated to develop in a great variety of very different ways. But certain pathways to development may be mutually exclusive. For example, if a college tries to promote what some alumni groups call

"loyalty and guts," it may be difficult for it also to promote such a quality as the critical use of intellect. Or in the case of small children, major emphasis on the group, as in the Israeli kibbutzim, may make it very difficult for a child to develop the intense attachment to a single mothering person that is characteristic of good family life in most Western societies.

It is not enough, then, to talk merely about "normal development" as the goal of a developmental institution. We know that parents have unconscious, preconscious, and conscious objectives in child rearing. They try to prevent Johnny from becoming like his alcoholic Uncle Harry; or to encourage Gertrude to become like her mother; or to develop orderliness, neatness, and parsimony in one child, or grace, freedom, agility, and imagination in another. The enormous variation in personalities produced by ordinary "healthy" families suggests that it is almost impossible not to stimulate certain developmental potentials and to inhibit or retard others.

But in a developmental institution, in contrast to a family, the normative question—what is "normal" development?—has to be made far more explicit and conscious in planning, programing, and evaluation. In these processes ethical questions cannot be avoided, they can only be evaded; and when they are evaded—when they are not openly faced and rationally considered—the results may be disastrous. For example, one way of characterizing those hygienic institutions whose toll on children's development has been so well documented [3-5] is to note that they have answered the normative question with an unconscious decision to produce children who will be as little trouble as possible, a goal that can be reached only by sacrificing the child's individuality.

Some American colleges operate with a comparable unconscious goal—to keep their students out of trouble until they are old enough to enter the labor market. Fortunately, adolescents are more resilient and rebellious than infants and can sometimes overcome this kind of pressure. But the long-run consequences of having this goal may be only slightly less deplorable than the consequences of having the goal of keeping children out of trouble in an antiseptic nursery. In children's institutions and in colleges alike, it is crucial to examine, reflect upon, and make explicit the specific developmental and educational objectives of the institution.

2. *For what kind of society?*

The second crucial issue raised by the study of alienated students is closely related to the first. It has to do with the nature of the society into which the developing individual will eventually move, and the demands, characteristics, and needs of that wider society. If, for example, it were clear that we lived in the best of all possible worlds, then alienation from our present society would definitely be an irrational and deplorable response. We would prescribe therapy for the alienated students and abolition or reform for "alienating" institutions. Or if we felt that criticism of society was always destructive, we should similarly deplore any degree of alienation.

In other words, any judgment as to the kind of human development we should ideally promote must be closely related to our picture of the nature of the wider society, of the demands it makes, and of its long-range needs. A developmental institution is preparing individuals for a particular society with special characteristics, pressures, and opportunities. It may be, for example, that certain kinds of child rearing will produce the kind of character structure and personality organization that is well suited to a Polynesian village but profoundly unsuited to American society. Or again, the kibbutz system of child rearing may produce the kind of adult who contributes a great deal to a kibbutz but one who would be unhappy and unproductive in American society.

Thus, in planning for the program or staffing of a developmental institution, we must consider the kind of society in which the "products" of the institution will live and their capacity for fulfillment and productivity in such a society. This does not mean that our goals should be to develop people who will unreflectively "adjust" to society. Obviously society needs social critics, independent thinkers, and even alienated men and women. But social critics also have to function within society.

Another study I have been involved in raises two more questions that are relevant to program planning in a developmental institution. This is an exploratory study of talented college dropouts. Every year hundreds of thousands of talented well-

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Kenneth Keniston is associate professor of psychology and associate director of an advanced training program in social and community psychiatry at the department of psychiatry of the Yale University School of Medicine. He has also taught at his alma mater, Harvard University. He received his doctoral degree from Oxford University.

prepared young Americans drop out of colleges before graduating. We are trying to find out why. What does this mean in relation to the student's development? For whom is dropping out a progressive step, and for whom is it a regressive step?

This research at Yale University is in midstream. We are not even sure of all the questions we will ask, much less of the answers. But we are beginning to believe with Anna Freud that dropouts are people for whom the 4 years of college come at the worst possible time from a developmental point of view.[6] They feel, consciously and unconsciously, that further psychological development is impossible as long as they remain within a collegiate setting; and in many or most cases, they are probably right. At least those who return (the majority) believe that their years away have enabled them to grow and mature, and the judgments of their friends and teachers usually confirm this belief.

In our exploratory clinical studies, we have found that dropouts often have difficult problems of identification with their parents, problems that seem to prevent that slow and gradual development of commitments and the consolidation of identity that usually take place in students of their age. And one reason why dropouts find these problems (which are, after all, universal) so difficult to resolve within a collegiate context has to do with their perceptions of the college environment.

Thus we find an almost universal but often unconscious tendency among these college dropouts to perceive the college as a whole as if it were a large-scale edition of their families. We have been repeatedly impressed with the striking parallel between dropouts' descriptions of the college and their descriptions of their parents. One sophomore, for example, was struggling with great problems of identification with a father who was overtly sadistic and brutal but who at the same time manifested through alcoholism an underlying passivity and dependency. This student describes the college as being authoritarian, harsh, and repressive, yet lacking in any real strength, decisiveness, or moral purpose. Another student, in the throes of attempting to reconcile conflicting identifications with warring parents, perceived the college as containing two conflicting sets of pressures, clearly identifiable with his parents.

This kind of "institutional transference"—equating the institution with the family—seems to be particularly widespread among students who drop out of college. Students who persist in college seem considerably less prone to identify college with their parents. To be sure, they, too, tend to relate to the institution globally, almost as if it were a family. But for them the college is like a *new* family, a facilitating, liberating environment in which they can escape earlier family pressures and move forward in their development.

Another incidental finding of this study is how few colleges recognize the existence of dropouts. Of every 100 freshmen entering 4-year colleges in America, only 40 graduate from the same college 4 years later. Transfers and temporary or permanent interruptions of college are the rule rather than the exception. But most colleges keep few figures about "dropouts," ignore their existence, or with little factual basis treat them all as psychological "misfits" or academic "failures."

This study of dropouts underscores two further issues that arise in all developmental institutions:

3. *What are the effects of the institution as a whole, of its climate, culture, or morale, on the individual?*

In the end, we can no doubt analyze a student's perception of a college into a thousand component interpersonal relationships and experiences. But the student himself experiences the institution globally *as an entity;* and he tends to relate himself to it almost as if it were a single, crucial person in his life. This fact may help explain one of the puzzling results of many studies of college students. It has been shown again and again that probably the most potent factor in determining how colleges affect students' development is that intangible quality called "institution morale," "college climate" or "campus culture." The effectiveness of an institution in promoting development seems more closely related to the characteristics of the institution as a whole than to any of its constituent parts—students, faculty, facilities, programs, residential arrangements, or curriculum.

In many discussions of the relationship of the college to students' development, this quality of "climate" is neglected, perhaps because it is so difficult to define and measure precisely. We hear endless discussions of curriculum reform, promotion policies, admissions procedures, and residential facilities, but very few discussions of how to create or facilitate the right kind of "climate" or "morale." Yet even an unmotivated and unpromising student, if he is fortunate enough to enter a first-class college with very high institutional morale, may find himself caught up in a general tide of enthusiasm that pushes him to a height of personal and intellectual development that he never before dreamed of. On the other hand,

even a highly motivated freshman, if he enters an institution with low morale, may stagnate or regress.

In young children the ability to relate to an institution as a whole is, of course, more limited than it is in adolescents. Nevertheless, in developmental institutions for young children, the climate of the institution as a whole may similarly be more important than any specific programs, staffing policies, or residential arrangements. It is conceivable, for example, that there may be institutions for children where the physical facilities are poor, where the staff philosophy is reactionary, and yet where—for reasons that we do not quite understand—children manage to flourish and grow. And it is also possible that there are institutions with advanced facilities and modern ideas about child development where for lack of a good "climate" somehow everything seems to go wrong, including the children's development.

In thinking about how to create institutions that encourage human growth, we must recognize that individuals experience and respond to institutions as a whole, not only to their parts. We therefore need to plan not merely for programs, schedules, living arrangements, and so on, but also for how all of these variables might interact to produce the kind of staff morale, institutional climate, and intangible culture that nourishes healthy development.

4. Can the institution deal realistically and supportively with individuals who are "deviant" or "atypical" in terms of its ideals and norms?

All institutions, and especially developmental institutions, tend to have an implicit or explicit image of the "average expectable individual," the "typical Yale man," or the "normal child." Procedures, programs, publicity, and even perceptions are organized around this image. At times in a college the image of "the typical student" is so powerful that it blinds administration and faculty to the fact that a majority of students in no way conform to this image.

Other developmental institutions also tend to develop systematic blind spots and irrational ways of responding to members who do not fit their definition of the "average expectable individual." Sometimes the existence of person who do not fit the expected pattern of development is simply denied by a refusal to notice that they exist. Sometimes those whose development deviates from the expected are treated as misfits, failures, or malcontents. In either case, their lives are dominated by fear, shame, and a sense of their own inadequacy.

One of the marks of a superior developmental institution, whether a college or a residence for children, is its capacity both to recognize explicitly and support persons whose developmental needs and schedules deviate from the mythical or actual norm—without needing to relegate them to a limbo of abnormality, psychopathology, failure, or nonexistence. Those American colleges that clearly facilitate genuine intellectual and personal growth are noted for their emphasis on encouraging individuality and recognizing the special qualities of each student.

Such colleges tend to have flexible institutional programs, to apply their rules according to the individual's needs and his development, and to be highly tolerant of dissent and deviance, both on campus and off. These colleges, and I suspect those children's institutions that facilitate healthy personality growth, explicitly recognize that individual human beings have differing needs at different stages of development, that the rates and phases of normal human growth are highly variable, and that, in a sense, exceptional development is not the exception at all but the rule in human life.

In summary

Thus, despite the real differences between children in institutions and students in college, similar issues arise with regard to both groups. Both groups live in "developmental institutions" and the effectiveness of the institutions in promoting their growth depends in good part on how well these questions are answered: What is "normal" development? For what kind of society? What is the right "climate"? Can deviance be accepted? Planning, maintaining, or improving developmental institutions, therefore, demands not only attention to sound programing, staffing, and financing, but also a rational and informed examination of the underlying goals for its residents in the context of what is known about human development.

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FILIAL DEPRIVATION in PARENTS of children in foster care

SHIRLEY JENKINS

One aftermath of the placement of children in foster care, the effects of maternal deprivation on the child, has been a subject for major research investigation. The reciprocal aspect of the placement transaction, "filial deprivation," or the separation experiences of the parent when the child enters foster care, however, has not been studied. In a society where the prevailing expectation is that parents will raise their own children, the failure to do so, with placement of progeny in settings outside their own homes under social agency care, is likely to have serious implications for the placing parents. How these feelings of separation from their children may affect mothers and fathers, and how their response patterns may be related to generalized attitudes of unworthiness or alienation are important questions. This paper reports on a beginning research effort to explore the concept of filial deprivation and to differentiate some of its dimensions by identifying feelings expressed by parents when their children enter foster care.

There are a number of reasons why clarification of the concept of filial deprivation is important to the better understanding of parent-child separation. When we consider the numbers of persons affected, the problem is of major proportions. There are over one-quarter of a million children in foster care in the United States at the present time, and any estimate of how many adults have at some time experienced separation from their children placed in foster care under agency auspices would come to several million. The fact that the placement of children away from home also tends to involve a disproportionately high percentage of families who live in poverty, including many families of minority groups, raises the further question of whether this failure to meet society's expectations is interpreted by members of these groups as likely to lead to reprisals, such as abrogation of parental rights and the loss of decisionmaking power over the raising of their own children.

There is also the question of whether the way parents experience filial deprivation has predictive value in relation to the eventual return of the children to their own homes. It may be that part of the readjustment problem of foster children who go home reflects not only their own separation trauma, but also the reception they receive from their parents when they return. In some instances, the family may, in a sense, have closed in behind the separated child, so that there is neither psychological nor physical space for him when he returns home.

The setting for this research is the Columbia University School of Social Work, where a child welfare research program, directed by David Fanshel and supported by the Federal Children's Bureau, is undertaking a longitudinal study of 600 children from approximately 400 families who have entered social agency foster care in New York City in the calendar year 1966. The study sample is limited to children who are experiencing initial foster-care placement, who have entered care before the age of 13 years, and who remain in care for a minimum of 90 days. These children will be studied from three angles: the child, his own family, and the agency which serves him.

Based on a paper presented at the 1966 annual meeting of the American Orthopsychiatric Association, San Francisco, Calif.

All children will be studied for a minimum of 5 years whether they remain in care or return home, and repeated measurements of child, family, and agency will be analyzed. These will include psychological testing and behavioral ratings of each child, and study of agency decisions and methods of care.

We expect the kind and degree of filial deprivation experienced in a family to be related to the problems that lead to foster care. A recently completed study by Jenkins and Sauber [1] revealed a variety of "main reasons" for placement. Of 425 families from which 891 children over 6 months old had been placed in care, from May through August 1963, as public charges in New York City, 29 percent had had the children placed because of the physical illness of an adult in the family; 11 percent, because of the mother's mental illness; 17 percent, because of the children's emotional or personality problems; 10 percent, because of severe parental neglect and abuse; and 33 percent, because of various other family problems, including parental incompetence, drug addiction, alcoholism, arrest, child abandonment, and unwillingness of caretakers other than parents to continue care.

In the majority of cases, the families were living in or on the edges of poverty and lacked supportive community services. Even in those cases in which the mother's institutionalization for mental illness was the main reason for placement, the interviews showed that the mother's mental breakdown was often associated with severe pressures from problems having to do with money, health, and housing. Data on parents' feelings associated with placement of their children must, therefore, be looked at in light of the factors causing stress in their families.

Review of the literature

The literature on maternal deprivation is singularly barren with regard to the feelings, reactions, and roles of parents when their children enter foster care. Bowlby in "Maternal Care and Mental Health" was chiefly concerned with the effect of severe deprivation on the emotional and personality growth of the child. He did, however, refer to the "vicious circle" resulting from unsympathetic handling by the mother when the returned child displays regressive, anxious behavior and note that "bad behavior" brings rebuffs and in turn rebuffs result in further "bad behavior." [2] In a review of the literature on maternal deprivation, Prugh and Harlow discuss "masked deprivation," in the parent and refer to what they term "distorted relatedness" and "insufficient relatedness" on the part of parent to child. As an example of the latter, they report that "situational factors involving current reality problems may produce pyschological disorders in the parent which may affect detrimentally the development processes of the infant." [3]

Some experimental studies of animal behavior contain observations that, although not immediately applicable to humans, raise some relevant questions about separation experiences. Blauvelt, for example, in her study, "Neonate-Mother Relationship in Goat and Man," describes how the mother goat establishes a territory, or safe area, near herself for her newborn kid. She suggests that when the separation of a mother goat and her newborn is achieved experimentally by introducing unexpected distracting or frightening stimuli, "if the mother and her newborn are not free to re-establish the normal pattern in the ways that are natural to them, it is possible that the mother animal will be unable to give the young the care essential for its survival at a later period." [4]

In describing readjustment problems of kittens after an experimental period of isolation from the mother cat, Rosenblatt, Turkewitz, and Schneirla note the changing patterns of mother-young relations in the litter period. They report: ". . . the litter situation confronting isolates returned from the brooder at different times differed radically from that prevalent at the earlier time of removal, especially as concerned the general behavior of the female [mother] and her responses to the kittens." The disturbed behavior in formerly isolated kittens returned to the litter was a result not of their experience in the brooder, but of their inability upon their return to make an appropriate adjustment to the changed pattern of the mother cat.[5]

In reporting on their studies of rhesus monkeys, Harlow and associates identify a point on a hypothetical graph of mother and infant contact needs where intensity is reversed and the infant's needs exceed the mother's. In an interpretation both alliterative and lyrical they say, "As attachment abates, ambivalence arises and anticipates alienation," and they go on to say:

> **From here on mother does not care**
> **For baby fingers in her hair;**
> **A touch that once went to her heart**
> **Now merely makes the hair depart.**[6]

The social work literature, like the separation material, stresses the child in placement, with concern being focused primarily on practical service prob-

lems and plans for care. Although a recent review of this literature conducted by students at the Columbia University School of Social Work [7] did not reveal any systematic study of parental reactions to separation from their children, it did identify several references to feelings of parents when children are placed in foster care.

Aptekar, for example, in discussing casework with the child's own family, notes: "Every parent . . . reacts in his own individual way—with his own personality and in the context of his own living problems—to . . . the placement experience. All of his important problems and all of his chief character traits will come out in relation to the placement. . . ." [8]

In a discussion of casework techniques, Britton states: "In all cases where parents have failed to keep their children there is a tremendous sense of guilt which can be completely paralyzing. . . . The result of this feeling is apathy and depression or the projection of their feelings onto some external factor or person whom they feel to be to blame for what has happened. The sense of guilt and resulting hopelessness can be so great that they repudiate the relationship altogether and feel no sense of responsibility." [9]

According to Smith, Ricketts, and Smith, parents who were questioned in a child guidance clinic about their experiences on and after separation expressed some relief from tension, but also feelings of intense loneliness, emptiness, and guilt. One parent said that the child's placement felt "like a death." [10]

Young, in discussing separation, states that parents who fail become objects of scorn in the community since child rearing is a responsibility of parents in our culture and placement of a child away from home tends to be an admission that individuals have failed as parents. [11]

Mandelbaum reports feelings of isolation, loneliness, and inadequacy in parents on placing children in residential treatment. He also reports that some parents expect punishment for having placed their children and express the fear that, when the children are grown and are "big and powerful," they will return to their homes to destroy their parents in retaliation for this wrong.[12]

These observations from the social work literature are interesting as points of reference, but their value is limited not only by a lack of systematic study, but also by the varying types of populations upon which they are based. The child welfare research program at Columbia University provides an opportuntiy for systematic access to a large sample and wide range of placing parents, including many whose children have entered care precipitously with little or no parental planning and even in some cases without their knowledge. The design is comprehensive enough to secure data broad enough to derive generalizations useful to the child welfare field.

Instrument construction

As the task of instrument construction for the present study began, it was argued that it was too soon to study "filial deprivation" in itself, that the first problem was to explore the possibility of developing such a concept. A variety of ingenious ways of getting at this in what one psychologist has called "reverse clinical English" were considered and discarded. The investigators settled for a direct approach: After the interviewer identified the main problem that brought the child into care, the interviewer said—

We would like to understand more about how people feel when their children go into placement away from home. How about you, how did you feel the day your child was placed?

This request for the parents' immediate reaction on the day of placement produces baseline information for later discussion of changes in feelings.

After the parents give a general statement of their feelings at the time of placement, they are asked to describe in one of the following words their strongest feeling on that particular day: hurt; angry; relieved; nervous; ashamed; numb; sad; bitter; thankful; worried; guilty; empty. These words were obtained from 1-word summary statements from 14 exploratory interviews, used for developing a checklist for the final schedule.

For any of these feelings noted, parents are then asked to indicate intensity by choosing between "very" or "just a little." This is followed by an inquiry into the object of each feeling. If a person says he felt thankful, for example, he is then asked, for what?; "guilty," about what?; "angry," toward whom? In this way responses are developed in terms of the different dimensions of feelings expressed, including the nature of the feeling, the extent of the feeling, and the object of the feeling.

To make the data more concrete, parents are also asked to report their actions on the day the child was placed; who was told about the placement; and what reactions were expressed by others. To distinguish the reaction to the separation itself from their reaction to the placement situation, the parents are asked if they would have felt differently if the child

had remained at home in the care of a homemaker; if the child had been placed with a foster family rather than in an institution, or in an institution rather than a foster family; if the child had been cared for by relatives or friends rather than by a social agency. They are also asked whether their feelings about the children's placement reminded them of anything from their own childhood.

The parents are encouraged to discuss the changes in their feelings about separation as time went by in relation to changes in their social and family life, such as changes in living circumstances, new housing, new employment, or new friends. To determine whether the feelings they express are borne out by their actions, the interviewers ask specific questions such as, "If you have moved, do you have a place for the child to sleep?" and "What was done with your child's toys and clothes after he went into placement?" The parents are also asked to finish a series of eight incomplete sentences to determine whether responses to such a projective device can give clues to the emotional investment of the mother or father in the child. For example: "For a mother [or father] a child is ———." "Taking care of a child is ———." "How a child turns out depends on ———."

These questions about the parents' feelings of filial deprivation comprise only one of six major subject areas in the instrument for studying the family. The responses to them will be analyzed in relation to the other factors being studied, such as reason for placement, social attitudes, child-rearing attitudes, and socioeconomic circumstances. Other phases of the overall research program will also provide opportunity for validation of interview data. Agency reports on the child's behavior during placement, for example, and on the parents' care of and involvement with the child will be related to data obtained directly from the parents.

Some feeling patterns

Since the interviews with the families are still under way, analysis of the data from them will not be ready until the end of 1967. However, we have some clues about filial deprivation based on analysis of data from 27 individual interviews (14 exploratory and 13 pretest) and 3 group interviews with parents whose children are in foster care.

The first conclusion from this preliminary experience is that the analysis of parental feelings about separation will reveal rather than any ordinal scale of intensity clusters of related reactions depending on individual personality factors, the situation that precipitated placement, and the role of the child in the parent's life. Predominant feeling tones, however, did appear in individual cases. Interviewers commented on the "sad" or "glad" or "mad" or "scared" groups of reactions. In addition, the "nothing" group—absence of feeling—appeared to be another syndrome.

Some of the comments of parents are revealing of both personality and situation. An alcoholic mother said, "I was sad, I was hurt, I cried all the way home. Now I knew I would be alone." Her main wish was "to live until I am 50."

A mother whose children were placed for neglect because of a fire said, "I felt empty, numb, like the blackout, like everything was out of my hands. Now I would have to prove myself all over again." Her wish—nothing.

A father whose wife was hospitalized said, "I felt good, glad, relieved. Now I knew they would be taken care of until my wife gets well." His wish was for his wife to get out of the hospital.

A 15-year-old unmarried mother, with no place to keep her baby, was "angry, mad, upset, resentful." "It's my child," she said, "and all those big shot people were telling me what to do." Her wish—"that I hadn't become pregnant until I was 18 and knew how to manage."

Each parent made such a variety of responses to the checklist of feeling words that "ambivalence" might seem to be the predominant reaction. Reference to the object feeling, however, showed that the reactions were not as chaotic as they appeared. One mother, for example, reported that she was "hurt" by her social worker from the public child welfare agency; she was "angry" at the worker; she was "ashamed" at not being able to provide everything her son needed; she was "sad" about being away from her son; she was "bitter" toward the worker; she felt "guilty" for having fallen into a trap. Another mother whose placed child was emotionally disturbed said she was

Shirley Jenkins, associate professor of social research at the Columbia University School of Social Work, is also associate director of the child welfare research program there. She was formerly an instructor at the Center for Human Relations and Community Studies, New York University. She is also coauthor with Mignon Sauber of "Paths to Child Placement: Family Situations Prior to Foster Care."

"hurt" by the world; "angry" toward her son; "relieved" at not having to care for him; "sad" and "guilty" for being a poor mother.

One interesting finding is the number of mothers who reported that they "went home and went to sleep" immediately after the placement was made. Another was that parents who expressed a great deal of love and concern for their children frequently told of carefully retaining such reminders of them as a christening dress, a teddy bear, or toy soldiers.

Several parents said that at the time of placement they had recalled their own childhood in foster care. One father said, "I thought back to the time I was placed when I was 8 or 9 years old. I felt funny inside like I was alone again. I felt guilty because when I was a kid I felt bad about going away and my kids had to feel the same way—but they were younger."

Problems and possibilities

These examples from the pretest and exploratory interviews indicate the kinds of problems that will have to be solved in the coding and analytic phases of the study. There will be three critical tests for use of the data: (1) Whether a typology of parents' feeling reactions to child placement can be developed that is conceptually clear and separates clusters of responses from each other; (2) whether these clusters are valid and meaningful in terms of other important study variables such as social attitudes, family pathology, and reason for placement; and, finally, (3) whether these clusters can have predictive value in relation to the child's later return to his home.

In discussing the effects of the separation experience on the child, Mary Ainsworth has reported that the child who has been placed away from home typically goes through successive stages of "protest, despair, and detachment."[13] Without therapeutic intervention, the result is the detached, hard-to-reach, emotionally blunted child. Although it is too soon to predict the outcome of our study, one might wonder whether the placing parent might not go through similar stages. Will the separated parents, depending on their circumstances, own history, and expectations for the future, fall into clusters of those who despair, those who protest, and those whose detachment is such that rejection and denial of parental roles cannot be breached? Such findings, if they do occur, might have implications for the kind of service provided parents at the time of placement as well as having predictive value regarding eventual family reunion.

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. . . And as men must now irrevocably perish or survive together, the task of each family is also the task of all humanity. This is to cherish the living, remember those who have gone before, and prepare for those who are not yet born.

Margaret Mead, in* "Family," *The Macmillan Co., New York, 1965.

FAMILY DAY CARE for children of migrant farmworkers

MARION L. SHERIDAN

Two-year-old Willie spent many weeks of his second summer under the neglectful eyes of his senile grandmother while his mother worked in the fields. Willie was often wet and hungry. His mother did not want to leave him but she did not know what else to do. The family needed her wages, and there was no one but the old grandmother to take care of Willie. Each weekday his 5-year-old sister went to a day-care center run by the county for children over 3, but there was no place for Willie to go.

Willie's third summer was different, however. He spent 5 days each week, from 8 a.m. to 5 p.m., in the care of a family day-care mother in her clean and pleasant home. Willie was never hungry; his health improved. He learned to play with other children. He was happy, and so was his mother.

Every summer hundreds of migrant farmworkers like Willie's parents come with their children to work in rural areas of Pennsylvania harvesting fruits and vegetables. The State has supported day-care centers and summer schools for the children of migrant farmworkers since 1955, but until the summer of 1965 it did not offer care for children under 3 years of age. A new service especially adapted to the care of young children is now developing, however, through which they can be cared for in family homes by the day. A pilot project supported by the Office for Children and Youth in the State Department of Public Welfare, the Pennsylvania State University, and the public child welfare agencies of three counties, the service has been carried out for two summers and will be continued in the summer of 1967.

The project was started after reports from social workers, nurses, and ministers working with migrant families pointed out the continuous need of migrant parents for ways of caring for their young children while they worked in the fields or for other reasons. These reports described conditions often physically harmful to children. Sometimes, for instance, small children had to stay all day in a bus parked near the field in which their parents were working and received only occasional attention from their mothers as the crew leaders permitted. Babies might be left unfed for hours. Social workers had tried to arrange for care in the camps for these children, but they found that only the most elderly or most irresponsible women remained in the camps at the peak seasons to care for children or that other children between the ages of 4 and 8 who should have been in the day-care centers were left behind to care for younger brothers and sisters.

These reports, together with statistics gathered from year to year on the number and ages of children coming with migrant farm families each summer to Pennsylvania, convinced the State Office for Children and Youth that it should try to provide care for children under 3 as well as for older children. Consequently, a pilot project in family day care was started in the spring of 1965 and was extended in 1966.

The project has several objectives: to find a way of caring for the young children of migrant farmworkers helpful to them and acceptable to their parents; to determine the problems involved in giving such care; to interest State and local child welfare agencies

in providing such care; and to compare this type of care with the group care provided for the older children.

Three counties in north-central Pennsylvania—Columbia, Luzerne, and Potter—were chosen for the project. About 1,600 migrant farmworkers come to Columbia County each summer; about 500 to Luzerne; and between 500 and 600 to Potter. The farms of Columbia County cover a wide area and the migrant camps are considerably distant from one another. For this reason, services for migrant children such as day-care centers and summer schools are located in Bloomsburg, a community nearly equidistant to all camps. In Luzerne County, such services are located in small villages near the camps. In Potter County, which has one large centrally located cooperative camp for migrants and many small scattered camps, most of the services have been located near the central camp.

Setting up the service

These three counties were chosen for the pilot service project because they had well-established public child welfare agencies and because an increasing number of migrant workers with small children come into the counties to harvest their crops each year. As the State Department of Public Welfare through its child welfare program has supervised these agencies for many years, it was not difficult to work out plans quickly and easily. The department agreed to pay for the entire project and to furnish social workers to the county child welfare agencies, which in Pennsylvania are under the county commissioners, to carry it out. Though directly responsible to the supervisor of special services in the State Office for Children and Youth, the social workers would work closely with the directors of the county child welfare agencies.

Marion L. Sheridan, supervisor of special services in the Pennsylvania State Department of Public Welfare, administers a program of social services, including day-care centers and family day-care homes, for the children of migrant farm workers. A graduate of the University of Pennsylvania School of Social Work, she has long been in the field of child welfare, as a county director, field representative, and consultant. She has also been a member of the Committee of East Coast Officials on Migratory Labor.

The directors of the county agencies gave the social workers the names of persons who might apply for children for foster care and assisted them in setting up a general policy for the acceptance and supervision of day-care homes and establishing a rate of payment to the family day-care mothers exceeding that established for foster care, but which the county agency thought justifiable for the service required. The social workers and county directors together regularly reviewed applications and approved each family before a child was placed.

The project in operation

Most service programs for migrant farmworkers in Pennsylvania last less than 3 months. For this reason, it was difficult to recruit trained child welfare workers for the program, most of whom have or want permanent positions. We, therefore, employed recent college graduates. What they lacked in experience they made up in enthusiasm for social work.

These young workers were assigned to the counties 2 to 3 weeks before the farmworkers were expected to arrive to give them some time to become acquainted with the methods and philosophy of the day-care centers for the children of migrant farmworkers, to visit people in the community to find out their attitude toward the new program, and to begin their orientation to the family day-care program through conferences with the directors of the county child welfare agencies.

Recruiting homes for family day care for the children of migrant farm families is no easy task because there is no way of knowing how many children will need care before the families arrive. To offset this uncertainty, in the early spring of 1965, each public child welfare agency reviewed its applications for foster care of county children and considered which families might be interested in providing family day-care service to the children of migrant workers. By the time the social worker arrived in the county, some families were prepared for her first visit. Having a few applicants approved for study by the agencies encouraged and helped new social workers and eased the job of finding homes. In the spring of 1966, the procedure was repeated. Recruitment began with the family day-care mothers of the year before. All but two reapplied and were accepted.

Each summer when most of the migrant farmworkers had arrived, the family day-care social workers visited the camps with social workers from the day-care centers and together they enrolled the children

for both programs. Much of the groundwork for the new program had been done during the many summers that the day-care centers had been in operation in these counties. Farmers and crew leaders accepted the social workers in the camps. Mothers already familiar with the work of the day-care centers welcomed them. Over the years they had learned to trust the social workers and teachers to provide good care for their children. They now accepted the explanation given them regarding family day-care for small children. After the children were enrolled, the social workers made plans for transporting them to the family day-care homes and to hospitals and clinics, and helped family day-care mothers and the children's own parents understand the problems a young child faces in leaving home daily and in growing up.

There were, however, critical moments each spring as the program began when it seemed that not enough homes would be available. Both years, local newspapers carried short articles about the family day-care project and radio stations in the area made announcements about it. The greatest help, however, came from the churches in the communities. (All services for migrant workers in the area have been achieved with the close cooperation of church and governmental agencies.) The State Council of Churches, an association of Protestant churches, gave wide publicity to this program and local clergymen in the three counties made direct appeals to their congregations for day-care families.

When the project began in 1965, two county agencies expected to provide care for 19 children under 3 years of age for 10 weeks. As it worked out, they provided care for 29 children in 6 family day-care homes. In 1966, although a late harvest season brought fewer workers than usual, the three county agencies placed 66 children in 20 homes.

Daily attendance of the children in their day-care homes both years was high. In 1965, in Columbia County, of the 35 days of care given 27 children, 3 attended all 35 days; 5 attended for 29 days; 13, for 25 days; 3, for 20 days; and only 3, for less than 20 days. Attendance for 1966 was at about the same level. The good attendance record seemed to indicate that parents needed the service.

Quality of care

Most of the couples who applied for these children were young couples who had young children of their own, lived in modern, ranch-style homes or remodeled farmhouses, and had good incomes. We had hoped,

A family day-care mother helps one of the two migrant children in her care get ready for the trip back to the camp.

that with the help of the social workers the families would provide good child care for the migrants' children, but most of the families with whom children were placed exceeded our expectations. In our initial study of their homes, we learned from the kind of care they gave their own children that their knowledge of modern methods of child care and nutrition was good and that they were able to be firm with children without resorting to punishment.

The comforting they gave sick or fearful children was perhaps the best feature of the care they provided. Many migrant children have poor health because of the conditions under which they live. Therefore, many of the children were ill during the time of care. One day-care mother rocked and held a child with an ear infection over and over for days until the condition cleared up. Another, on the advice of a physician and the consent of the mother, kept a child who had a high fever in her home for several days.

The day-care mothers were equally sensitive to the needs of fearful children. One social worker, in telling the supervisor of an experience she had in visiting a day-care home, said that when the day-care mother heard a slight cry from the bedroom in which a 2-year-old child was sleeping, she excused herself, went to the bedroom, and returned with the child in her arms saying, "Joyce Ann is always frightened when she awakens, so I pick her up and rock her for a while."

As time went on each day-care mother expressed more and more concern over the deprivation the children suffered. They helped the parents in various

ways from time to time. For example, on hearing that the parents of the two children for whom she was caring had been hurt in an accident, one day-care mother took them and the older children of the same family into her home and cared for them until their parents were released from the hospital.

The day-care mothers' enjoyment in caring for these children was apparent when 12 of the day-care mothers in the Columbia County program met one evening last summer. In exchanging ideas about child care, they told of the pleasure their work with the day-care program gave them. For example, one mother who had had a major operation followed by a post-operative reaction the spring before said she had not taken a sedative since she had had the children in her care, in fact, had not had time to "take pills." The day-care mothers were full of compassion for and understanding of the migrant mothers. They wanted to know how the mothers kept the children so clean and taught them to be so polite when they work such long hours. Although there was no formal plan for the children's own mothers and the day-care mothers to meet, they did find many natural ways of keeping in touch with each other. The day-care mothers sent notes home; they talked over the telephone with the children's mothers; and a few visited the mothers in the camps. Next year, we hope, migrant parents will be able to visit the family day-care homes.

To be sure, not all homes gave the same high quality of care. One of the first applicants in the 1965 program was a woman who lived in a large farmhouse with a wide porch surrounded by plenty of outdoor play space. At first she was enthusiastic about caring for migrant children. Because she was a farm woman who had brought up a large family, it seemed likely that she would do well as a family day-care mother. However, after the worker's first visit, the woman began to vacillate, to show fear about health problems, and to resent having to have a health examination and a tuberculin test to meet agency requirements. It was obvious that she would be both demanding of and dependent on the social worker. However, because in working with migrant children the agency has to work quickly if the need is to be met and as it appeared that this woman could give good care to children, the social worker decided she could help her with her personal problems. So, within 2 weeks we placed five children with her. Soon the worker found that the woman was leaving the full responsibility for the children to her 16-year-old daughter and her own mother while she went on with her usual household duties without involving herself with the children in any way except to prepare the noonday meal and to feed them with the family. The children received physical care to be sure, but little mothering or other individual attention. The worker soon moved all the children except one child to other homes.

The problems

Among the problems the project expected to have to solve, the first seemed to be how to place Negro children with white families. Because Negro migrant farmworkers had been coming to these communities for many years and because the applicants for migrant children initiated contact with the child welfare agency, we assumed that each family offering help knew that the children were Negro. The social worker, however, gave each day-care mother an opportunity to discuss any problems she might have relating to the difference in race; but no mother ever pursued the question except in terms of the health of the children to be placed. Once the children were in the homes, a natural relationship developed, as it does with almost any group of children. Almost all day-care mothers were so warm and loving that soon their own children and the day-care children were playing together freely and naturally.

Some resentment arose in some neighborhoods, however. A few adults asked provocative questions of the day-care families and some schoolchildren made malicious remarks to the children of the day-care families. No argument or insult seemed to have much effect on the day-care families, however, probably because they were convinced that what they were doing was right. One day-care mother from an upper middle class suburb told her neighbors that she knew of no better way of preventing her children from acquiring racial prejudice than to have them play and live with children of a different race and culture.

The second most important problem seemed to be that of the general health of the migrant children. During routine examination and immunizations at the county child health agency, we found that some of the children needed additional medical care and that many suffered from the complaints of children who do not receive adequate health services. Eight of 27 children in one program had umbilical hernias; 2 needed remedial surgery. Most of the children had colds and coughs, conditions that particularly plague migrant children, who must adjust to constant

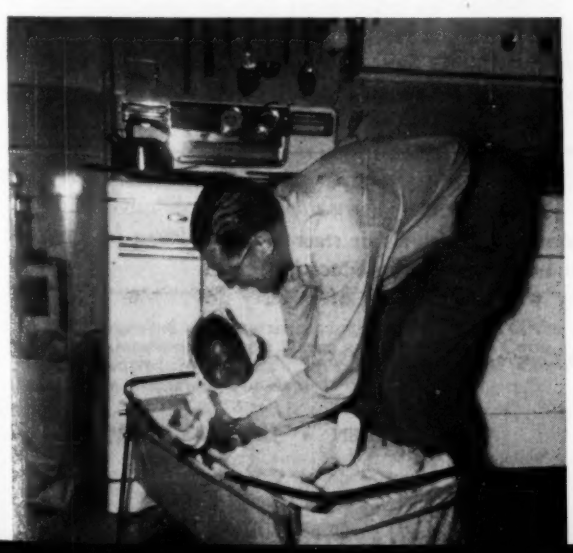
temperature changes, because, even in the fall, migrants live in barrack-like houses.

Transporting the children to and from the family day-care homes was also a major problem for the program. In fact, we found transporting children to be the most costly and difficult part of the program. In the first year, we planned to use the buses that carried older children to and from the day-care centers to bring the young children to the foster family homes. However, the drivers refused to be responsible when they realized very small children were to ride in the care only of older brothers and sisters. We, therefore, used several other methods of transporting the young children back and forth. At first we tried to use commercial drivers by hiring small buses and taxicabs. In one county, when this proved too costly, a few mothers who had applied for children but whose homes were not then in use agreed to transport children to the homes of other families until they themselves had day-care children to care for. One migrant mother who owned a car brought the children from her camp. All noncommercial drivers were required to carry extra insurance, and all drivers had a paid assistant who watched the children. At times, lack of transportation prevented our offering the service in certain camps because the cost of picking up two or three children at a great distance from the homes was prohibitive.

At first, the day-care mothers were overwhelmed at the thought of assuming the care of six children, as we at first asked each to do. Three children seemed to be the most each woman felt she could manage. A few day-care mothers, however, after having cared for three children for a week, decided that the task was not so difficult as they had expected and agreed to take one or two more. A few mothers even accepted six children.

The social workers gave constant support to the family day-care mothers by visiting the homes almost every day. They helped the mothers understand the children's behavior and find ways of making them happy. They discussed the health of each child and made appointments with physicians and nurses at nearby clinics and hospitals. They purchased diapers, training pants, nursing bottles, and extra clothes for cold days with money collected in fees paid for these necessary articles. Neighbors freely lent play pens, walkers, and cribs, and the day-care centers made cots available to the homes.

A foster family day-care father greets a baby who has just arrived from the migrant camp. Another migrant baby being provided day care in this home is not shown in the picture.



Mothers and children

We have found in working with migrant mothers that they seem to reach out at all times for any service that can improve the welfare or education of their children. Some of the migrant mothers readily took the morning or afternoon off from the fields to take their children to child health clinics at the request of the social worker, even though it meant a significant loss of wages. When a mother received a note from the social worker or the day-care mother by way of her child, she usually returned a written reply or discussed the matter with the social worker when she saw her next. During an outbreak of influenza in one camp, the social workers sent notes to migrant mothers describing the best diet for their children and asking them to report any symptoms of the disease. As a result, one mother reported that her child had a rash on her leg. The social worker and the family day-care mother thought the rash serious enough to require a visit to a physician. After examination, he sent the child to the hospital to be treated for a staph infection.

The parents paid the agency from $1.25 to $2 a week for the family day care, but any amount they could afford was acceptable. Almost all parents paid something willingly.

Most of the children adjusted well to the family day-care homes. Although the cultural and environmental changes often seemed too great for these little children at first, by the third and fourth day the initial reaction of most of them—whether tearful, moody, silent, or hostile—began to change. They became interested in the family day-care mother and the other children in her care and seemed cheerful and happy most of the time. However, if it appeared

within a few days after a young child was placed in family day care that he was not ready to be separated from his mother, we helped the mother make some other arrangement such as helping her to see that the child needed her at home or, if she had to work, helping her to find care in the camp or to place an infant in regular foster homes of the agency.

The greatest environmental change for the children was in eating and sleeping habits. These children seemed to sleep more than other children of their age. Although many children sleep to escape change, it was evident that these children slept from exhaustion as well. Camp life is noisy, and the camp settles down later than most communities, especially on a weekend. Most of the children in family day care had to have two long naps a day. Nearly all seemed to be afraid to be left alone to sleep, and they did not outgrow this fear, although they were accustomed to having little or no attention paid them while their mothers were working. One child, upon waking and being picked up by the day-care mother, looked in her face with surprise and asked, "Don't you have to work in the fields?"

After one little girl had slept all day in the family day-care home and could hardly be awakened to eat, the social worker asked the child's mother in the migrant camp whether her child had been sick the night before. The mother replied in surprise that the child had been well enough to run around the camp all night.

The family day-care mothers reported that the children ate well once they became accustomed to a few new dishes. Some of the children were still young enough to be bottle fed; others brought bottles as pacifiers, but once they were given solid food, they gave them up.

Although only observation and judgment have been used to evaluate the service, we believe that the purpose of the family day-care program was in general achieved, particularly in 1966. Migrant mothers accepted the family day-care homes because they trusted the social workers and were willing to learn from them and the day-care mothers how to improve the care they gave their children. Much improvement was accomplished in the care the migrant mothers gave their children through imitation with no words spoken. For example, if a child went home with a note pinned on his diaper saying "better way," he was likely to be returned the next day with the "better way" faithfully copied.

We were surprised how many family day-care mothers in the communities trusted a new and different program when supported by the county child welfare agency and, as a result, gave intelligent and loving care to children regardless of motivation. Our need to find these homes quickly engaged the interest and assistance of many people in the community. Newspapers, radio stations, and churches not only provided publicity for the program, but also served as avenues to good will.

As for a comparison between the value of family day care and the group care at the centers, we believe that a day-care mother caring for three to six children can meet the physical and psychological needs of young children more immediately and personally than teachers providing group care. This does not minimize the value of the care given at the day-care centers, but it does point up that in family day care the caretaker can identify and concentrate on the special needs of each child. A day-care mother in her own home can be close to the fearful child who needs to know immediately on awakening from a nap that he is not alone, and she can comfort a child during the long day when he suffers from a painful illness. The physical problems of children who have had no medical care can well take most of a day-care mother's day; yet the day-care mother must also alleviate the fears that accompany a new experience. The quick response of these children to the change of environment, methods of care, and improvement in health led us to believe that, for young migrant children, family day care can be a valuable experience.

. . . We owe to every young person in America a fair start in life—and this means that we must attack those deficiencies in education, training, health, and job opportunities by which the fetters of poverty are passed on from parents to children . . . .

President Lyndon B. Johnson to the 88th Congress, January 21, 1964.

two psychiatric clinicians discuss their experiences in . . .

LEARNING with TEACHERS

ALBERT J. SOLNIT, M.D. ● MARY H. STARK

Schoolteachers and clinicians from pediatric and psychiatric clinics for children have much to learn from each other about child life and child development. Long convinced of this fact,[1-3] the Child Study Center at Yale University has for more than a decade been engaged in a continuous collaboration with two local school systems in Greater New Haven, Conn. This collaboration has underscored the reciprocal value of a close working association between teachers and clinicians. The experience has also impressed the clinicians engaged in it—a child psychiatrist and a psychiatric social worker—with the potentials of the universal education system as a preventive force in society's struggle against an alarming incidence of mental illness.

We began the experiment with an effort to establish conditions in which we could make our clinical understanding of children and their families available to schoolteachers. At the same time, we wanted to tap the enormous reservoir of knowledge and experience schoolteachers had gained about children in their daily experiences. Being aware that teachers and clinicians possess knowledge derived from different levels of observation and inference, we hoped thus to enrich our own work as teachers of medical students, pediatricians, psychiatrists, psychoanalysts, nurses, and psychologists.

The work reported in this article has the endorsement of the Boards of Education of North Haven and New Haven, Conn., and is supported by the Children's Bureau and the Connecticut State Department of Health.

Since then we have engaged in a continuous collaboration with schoolteachers in elementary schools in the greater New Haven area—especially in two schools, one in an upper middle class professional community and the other in a poverty-stricken area. Our work with the teachers has focused on children with problems in learning or school adjustment.

Assuming from the beginning that the school's major mission is to provide each child with educational opportunities that are optimal for his development in a democratic society, we have been mindful of the confusion that results if teachers are expected to be diagnosticians and therapists and, conversely, if child psychiatrists, social workers, and psychologists are assumed to be experts in child education. Nevertheless, we have found that each group of experts can learn from the other by making appropriate and selected translations and inferences.

Each year we have met with groups of teachers regularly throughout the school year on a weekly, monthly, or bimonthly basis. In one school the group consisted at first of 8 to 10 teachers of the first, second, and third grades; then of teachers of kindergarten, first, and second grades; and later of teachers of the second, third, and fourth grades, and so on. The school nurse, social worker, and psychologist also attended the meetings. Thus, over a 5-year period, all of the teachers in this school (which covers kindergarten through the sixth grade) participated in the conferences many times. In another school the conferences were limited to six kindergarten, first-, and second-grade teachers. In every instance the

principal of the school has been present at the meetings. In addition, special teachers such as speech or remedial reading specialists have been included when a child or a problem of concern to them was under discussion.

From the beginning, we have stressed both the scope and limitations of our expertise as a psychiatrist and a psychiatric social worker, pointing out that we were interested in a true interprofessional exchange of knowledge. In this way we have gained acceptance of the project in the school community—a prerequisite for fruitful collaboration with the educators.

The meetings have been intended to serve as a means of exchanging opinion and knowledge for the benefit not only of the child under study but also for other children, since the discussions have usually generalized from the particular child under consideration to others with similar characteristics or problems. Most of them have been organized to focus on a particular child and the teacher's efforts to help him, but the discussion has often broadened to a consideration of questions of general concern such as discipline, curiosity, or socialization in early adolescence. Before each meeting, a short statement about the child and his problems is sent by the principal to the clinical group. Confidential information is protected by measures designed to insure the anonymity of the child.

As the teachers discussed a child, his school experiences, and his background, we attempted through questions and comments to convey some insights gained from our clinical experience and studies in the fields of psychoanalysis, child development, family dynamics, and child psychiatry. The discussions enabled the teachers to translate these insights into working knowledge that could be applied effectively in dealing with the child and with specific learning situations in the classroom. Thus, we did not emphasize psychiatric diagnosis or referral for clinical care. In fact, over a 10-year period only a small proportion of the children we have studied in these group meetings have been referred to community agencies for pediatric or psychiatric evaluation and treatment.

Underachievement

Underachievement in its various aspects was the most frequent school difficulty to come under discussion. The teachers often implicitly or explicitly correctly related this problem to the child's preceding and continuing experiences at school. Often they also exhibited an awareness of the relation of the child's family background and his parents' attitude toward education to his underachievement.

By comparing the child under discussion with others in his class and by comparing his experiences and performance under a previous teacher with his present performance, the group invited a careful study of the reasons for the underachievement. This led to such questions as: Is underachievement in this child a result of an internalized conflict, a reaction to conditions in his home, an adaptation to the deprived environment, or a reaction to his present teacher or fellow students? In other words, is the difficulty in the child himself or is he reflecting the underachievement of his family, his neighborhood, or his subculture? For example:

Johnny, age 8, had been promoted to the third grade with reservations about his skill in reading and writing, subjects in which he seemed to have very little interest. Johnny and his parents had moved from South Carolina 2 years earlier and were living in a New Haven slum. His parents, according to the teacher, viewed school as a duty a child must accept pleasantly until he is 16, when he is permitted to drop out of school and go to work. They did not regard reading and writing as being as essential for adult work as skills requiring muscular coordination and strength. While they would like to have had Johnny do well in school, academically and socially, their compliant attitude toward the school's expectations did not have as much influence on Johnny as their implicit lack of interest in the goals of schooling. Johnny did not have any notion that schoolwork was an essential investment in his future.

The teacher-clinician group considering Johnny agreed that it would be helpful to Johnny if someone worked with his parents. At the psychiatrist's suggestion, the principal asked them to come to the school, thus demonstrating his interest in Johnny and his parents and in Johnny's schoolwork. He talked to the parents about how they might help Johnny do better work. He established a very good relationship with them and saw them several times. In the ensuing year, Johnny gradually gave evidence of taking his schoolwork more seriously. His changed attitude, as well as that of his parents', was at first manifested in a changed appearance. He seemed more rested, and his clothing and bodily cleanliness were obviously receiving more parental attention. His schoolwork slowly improved, as did his interest in demonstrating his proficiency in learning. His parents became active participants in the PTA and exhibited a possessive pride in the school.

When a child is not achieving at his capacity regardless of the cause the teacher often feels that she is underachieving. A study group discussing such a child can encourage the teacher to balance her self-criticism with a long-range perspective to transform her scrutiny of the situation into a constructive instrument for her own and her pupil's advancement.

Therefore, our questions and comments as clinicians were aimed at bringing out as full a picture as possible of the child's background, his different ways of learning in various situations, and his assets and liabilities. We would often start the discussion with speculative formulations about the child's failure to function up to par in school. The teachers would respond with additional observations and with their own formulations. The dialogue would then proceed until the teachers had devised the beginning of a plan to help the child.

For example:

The case of Phil, a very bright 11-year-old sixth grader, was presented for discussion because he never worked up to capacity. He daydreamed constantly and was very forgetful. Each teacher he had had for the past 3 years had made the same complaints about him. In the discussion group his fourth- and fifth-grade teachers, as well as his current teacher, Mr. A, were present. They reported that Phil was aware of his problem and often said with tears in his eyes that he wanted to do well in school but that he could not concentrate. He did show an interest in science, especially in relation to the human body. He also read a great deal and was in the top reading group in his class.

Asked by the psychiatrist to describe the boy, the teachers said that he was slender, average in height, rather awkward, and not skillful in sports; that he played with one or two rather unpopular children; that his classmates often responded to his forgetfulness and daydreaming by exclaiming, "Oh, Phil! Not again!"

At the request of the psychiatric social worker, the teachers described Phil's family.

Phil's parents were college graduates. They had removed all distractions from Phil's room at home in an effort to help him concentrate on his homework, but he had continued to daydream. He had a very bright sister who was in the fourth grade, a 6-year-old brother with cerebral palsy, who was not able to go to school, and two sisters of preschool age. Phil's father had said that he himself did not "wake up until he was in college."

When the psychiatrist asked if Phil ever requested help from his teachers, Mr. A, his current teacher, reported that Phil was very independent and did not ask for help. His fourth-grade teacher remarked that Phil would "tune out" the teacher and would always seem to be interested in a topic different from the one assigned. Mr. A had spoken to Phil after school about his daydreaming and forgetfulness but this had not helped. He had also had a talk with the boy's parents but this approach had not helped Phil.

The psychiatrist commented on Phil's advanced reading and on the universality of daydreaming, a form of mental scanning that ordinarily facilitates problem-solving mental activity and the acquisition of knowledge. He speculated that in Phil's case the inability to concentrate on what the teacher asked might be a bright boy's way of presenting himself as defective. The psychiatrist further suggested that Phil's associations with going to school might be related to his concern about his handicapped, younger brother, who had been born about the time Phil entered kindergarten. He added that perhaps Phil had identified himself with his defective brother as a way of coping with his own feelings about separation from his mother at a time when she was painfully preoccupied with the tragic condition of her newborn son. The teachers discussed this idea as a possibility worth further consideration.

Both Albert J. Solnit, left, and Mary H. Stark are associated with the Yale University School of Medicine and the Yale Child Study Center: Dr. Solnit is professor of pediatrics and psychiatry and director of the center; Miss Stark is an assistant professor of social work in the medical school's department of pediatrics.

Mr. A suggested that as the first step in an educational plan he and the principal might talk again with the parents to try to find out what might be worrying Phil. The group went along with this, pointing out that Mr. A would then be in a position to decide how to deal with the boy. The group agreed that the teacher should in some way convey to Phil that daydreaming was all right as a companion of but not a replacement for the problem-solving effort involved in schoolwork.

The group did not come to an agreement on whether Mr. A should bring up the subject of the younger brother in talking to Phil. One teacher insisted that Phil's curiosity about the human body offered a logical opportunity for talking with him about his brother's handicap. The rest of the group, including the clinicians, felt that the subject would best be broached by his parents or physician. Phil's teacher, the group agreed, should understand the possible influence of the brother's arrival and condition on Phil but should not accept this as an excuse for Phil to limp along in his work. Some of the teachers pointed out that if more were not demanded of Phil in school, he would regard his distorted impression of himself as correct.

The educational plan devised in the group was modified as a result of an ensuing discussion with the parents, who had responded to the suggestion that Phil might be concerned about his handicapped brother by agreeing to help him attain a better understanding of himself and his family. In accordance with the plan, the teacher insisted tactfully and repetitively that Phil practice and complete his work in a manner suiting his capacities; refrained from criticizing him for daydreaming when he was not reciting or engaged in problem-solving activities; and

conveyed disagreement with Phil's notion of himself as a handicapped boy who could not perform. The teacher did not initiate discussions with Phil either about his brother or about the body in general, but he responded to questions and observations on these subjects if Phil brought them up.

Six months later, Phil's teacher reported that the boy was performing better as a student though he was still occasionally absentminded and socially awkward. The social awkwardness was no longer a major concern, since the parents had reported Phil had a good relationship with them and their other children.

Obstacles to learning are commonly engendered by the child's previous experiences, motivational conflict, poor impulse control, or a neurophysiological deficit that impairs the child's ability to attend to and acquire the mastery of symbolic expression so essential for formal education. We have observed that the effective teacher begins by providing a learning experience that avoids the obstacles to learning and only later takes a more direct approach to these obstacles. For example:

A teacher noted that an 8-year-old boy became frantic when reading out loud. She, therefore, avoided calling on him in class to read but did call on him to recite in other areas in which he showed confidence and pleasure, especially arithmetic. She also had him read to her alone during several recess periods, and after he showed some improvement she began again to call on him to read aloud in the class. This pupil gradually mastered the difficulty. The teacher did not know for certain what the origin of the difficulty was but suspected that it was related to an unfortunate experience the child had had with a speech difficulty earlier in life.

Some teachers intuitively devise a way of avoiding the obstacles to learning by following clues presented by the characteristics of the teacher-pupil relationship. One teacher placed a hyperactive 9-year-old boy next to her desk because she noted he could pay attention to arithmetic and its abstract symbols only when he was close enough to feel her controlling physical presence and interest in him. In another instance, a teacher placed a 12-year-old girl in the back of the class when she noticed that the girl had to show off if she felt "too close" to the teacher. Initially, she could learn more effectively when the relationship to the teacher was not intense.

Inservice training

From these experiences in collaborative assessment of underachieving children, we have become aware of the value for teachers of a planned collaboration with seasoned educators, child psychiatrists, and social workers as a form of inservice training or as an internship for new teachers. Younger teachers found the sessions particularly valuable, but older, more experienced teachers also gave evidence of gaining from their participation in the groups.

We learned that the first 2 or 3 years of full-time teaching are crucial in the professional development of young, inexperienced teachers. In a classroom, the full professional responsibility of helping 20 to 35 children learn basic tools of communication and the beginnings of conceptual thinking presents a challenge that is often overwhelming if the teacher does not have appropriate supervision and opportunities for inservice training. We have seen a bright, witty, young person who was given no supervisory help in mastering difficult work problems turn into a frustrated, sarcastic, yelling teacher. With supervision and conferences, the challenges a new teacher faces can be stimulating rather than overwhelming and they can result in professional growth rather than constriction. For example:

Mr. B, who had begun teaching fifth graders only a year before our conferences began, at first constantly tried to put children into the theoretical classifications he had learned about as an undergraduate. Toward the end of his first year with us, however, he remarked that the children did not fit easily into an extrovert-introvert classification system and that such a system was not very illuminating anyway. In the second year, with the support of his principal, he began to present some of the children in his class to the group: an 11-year-old girl whose shyness eluded his understanding; and a boy who in challenging his authority was provoking him to prove that he could be tough and was the boss. Through the openness of the discussion of these children, which continued from time to time throughout the year, Mr. B came to understand that the girl's shyness stemmed from anxiety about her sexual precocity and that the boy's provocative behavior was a poor form of sublimation and the displacement of sibling rivalry. Through his greater understanding of these children Mr. B was able to help them in class. He has often said that the conferences, which he attended for 3 years, have helped him build greater teaching skill on the foundations of his formal training.

In one school where the clinicians organized collaborative discussion groups, the principal ran the school like a "tight ship," partly in response to the threatening unrest in the surrounding underprivileged and disorganized neighborhood. However, he knew his children's families and their neighborhood well and made this knowledge available to the teachers in times of crisis. In the first conference at this school, a young kindergarten teacher described a child about whom she was concerned, and in doing so made it clear that she was being aided by an experienced, older teacher with whom she shared teaching respon-

sibilities. As the conferences proceeded, the clinicians' questions and comments stimulated the principal to transmit his knowledge of the families and home life to his teachers as a matter of course rather than only in crises. This enabled the clinicians to show how the characteristic learning and behavior patterns of the child under discussion were related to the dynamics of his family life as well as to difficulties specific to his developmental stage in the context of the cultural background. These phase-specific difficulties included anxiety arising from the child's separation from his parents or from the necessity to control impulses in the classroom. Thus, the assistance provided to the young teacher by her senior colleagues and by the principal became elaborated and explicit as we all extended our understanding about underprivileged children.

Pupil-teacher relationship

Thus we demonstrated that clinical theory mainly derived from psychoanalysis can be translated and applied as part of sound pedagogy when it is part of an inservice training program in which the questions, discussions, and solutions are related to everyday teaching problems and to principles of education.

One theory that seemed to be especially helpful to the teachers we worked with was the psychoanalytic concept of identification. This was presented as a complex psychological process through which attitudes and motives are conveyed from one person to another as a result of their relationship. We discussed those factors that promote and those that impede the adoption by the pupil of the teacher's attitudes toward knowledge, recitation, reading, and working alone or in groups.

Throughout the discussions, the clinicians attempted to show how the child's capacity to work at school can be activated through his relationship with his teacher, which, as Anna Freud has pointed out, is not a replica of "the child's emotional tie to either parent but something *sui generis*, a later, more complex, and more neutralized relationship to a group-leader figure." [4]

During this effort we observed that each teacher had a unique mode of describing and relating to her pupils. We also noted that each teacher had intuitively formed a fragmentary but influential relationship within 2 weeks after the school term had started with each of the pupils with whom she eventually became effective. When we called this to the attention of our educator colleagues in the groups as a phenomenon worth studying, they corrected us by pointing out that in most instances the period of "latching on" occurred during the first week of school. Some teachers said that if they did not have the beginnings of a relationship with a child before the first week had passed, they expected prolonged difficulties in teaching that child. The teachers gave many examples to show that their particular ways of reaching or influencing a child and a class of children required them to be able to identify in part with the children without regressing to poorly organized behavior and without losing their leadership of the class. Obviously, the full development of these alliances takes place throughout the school year. For example:

Mrs. C, an experienced teacher, reported that she had succeeded in reaching and influencing 7-year-old Jessie, who had begun school with a pattern of tardiness, by insisting that the child come to school on time. Mrs. C said that her insistence had conveyed to this underprivileged child that the teacher regarded her as worth troubling about. In the discussion it became clear that Mrs. C's "benevolent nagging" suited her style of making contact and represented the beginning of a positive relationship with the child and her parents through which they would come to identify with the school's goals for Jessie's education. When Mrs. C was asked at what point she thought she had begun to reach Jessie, she said that it was perhaps a few days after the opening of school when, feeling "nagged" by Jessie's tardiness and tired appearance, she had briefly suggested to the child that she get more sleep and come to school on time so that she could enjoy her schoolwork and do it better.

Thus, we learned that the teacher, even with a class of more than 25 pupils, intuitively at first and more consciously later, makes a unique arrangement with each pupil in her class as well as with the class as a group. This arrangement consists of a partial alliance between the teacher and pupil in which they implicitly agree to work together in a mutually satisfying way, each for different reasons and with different aims. For each party involved this alliance results in a degree of what psychoanalysts call "partial identification"—the child tending to adopt the attitudes and expectations of the teacher and the teacher recognizing the individuality of the child, through sensitivity to his special attitudes. Although this mutual, partial identification includes the friendly desire to please each other, it is not too intense and avoids the conflicts that are characteristic and even desirable in family relationships. It demands a degree of patience from each party and an ability on the part of the teacher to tolerate failure, anger, and disappointment while searching for a successful mode of working with the child, whether

through physical closeness or distance, verbal or nonverbal communication, special projects, or innovations suggested by teacher or pupil.

We have already mentioned the devices teachers improvise for initially avoiding obstacles to learning rather than meeting them head on. Such educational adaptations succeed when the teacher-pupil relationship has achieved the kind of beginning alliance in which partial identification can develop. The devices themselves, however, are derived from pedagogical principles that transcend cultural differences and modes of behavior. They exploit the various alternate senses available to the child for perceiving, organizing, and expressing mental impressions and rely on practice rather than drill. Drill imposes the adult's motives upon the child; but practice actively engages the child's positive motivation, a derivative of his identification with the teacher during the frustrating, often irritating, repetition of the work necessary for achieving mastery and independence.

Other aspects of clinical theory developed in our inservice training sessions included:

1. The relationship and differences between play as a method of learning for the younger child and the work of learning in the older child. (For example, play can be interrupted when it is no longer gratifying, but studying and working at school usually must be sustained through periods of discomfort and frustration before the desired pleasurable mastery of knowledge and understanding of symbolic processes are achieved.)

2. The necessary role of aggression in learning and the way the child's conflicting feelings about aggression bring about problems in learning.

3. The function of self-esteem in promoting or impeding the motivation to work at school or the capacity to adapt socially to the school community.

4. Awareness of phase-specific developmental characteristics as essential for gauging the pressure of frustration, the degree of anxiety tolerance, the function of daydreaming, and the significance of adolescent reactions in a particular child.

5. The role of cultural and developmental determinants in facilitating or blocking a fruitful alliance between pupils and teachers.

6. The assessment of the effects on the child's learning and behavior of a temporary or permanent physical handicap as a challenge for innovating educational experiences.

In conclusion

We believe that our experience over the past 10 years in collaborating with educators in group discussions has provided an effective exchange of knowledge about children and their families.

Some of the most important results of this exchange are:

1. An enrichment and refinement of knowledge among the educators and clinicians alike about what promotes and what interferes with a child's capacity to learn and develop in school.

2. A greater clarification of the distinctions in functions, methods, and content between the fields of pedagogy and of psychiatric clinical services for children; and a greater awareness of where they overlap in knowledge of and concern for children and their families.

3. A heightened awareness of the advantages of viewing the first years of a teacher's work as an internship requiring supervision and conferences for the continuing development of competence, creativity, and work satisfaction.

4. A clearer understanding of some of the psychological factors that determine the formation of alliances between teachers and their pupils.

On the basis of these experiences we are planning a more systematic and comprehensive collaboration with educators for assuring the availability to teachers of those elements of clinical knowledge that can serve the primary aims of education.

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A FAMILY PEDIATRIC CLINIC

at a community hospital

MILTON MARKOWITZ, M.D. ● LEON GORDIS, M.D.

In recent years, increased medical attention has focused not only on new diagnostic and therapeutic techniques, but also on the means of increasing the availability of these advances to the patient. It has become increasingly clear that progress in techniques has not been matched by comparable progress in dispensing these benefits to the American public. Nowhere, perhaps, is the gap between medical knowledge and its general application more apparent than in the care of the medically indigent, ambulatory patient. While communities have usually provided in some way for hospital care for the indigent, support for the medical care of ambulatory patients has been meager. But even where the financial barriers to care have been lessened through Federal or State aid, patients are still confronted with a major obstacle to good care—fragmentation of services.

This fragmentation is the result of a variety of factors. Modern subspecialization within specialties such as pediatrics has resulted in the proliferation of clinics, so that to receive complete care the patient must often be seen by many different medical specialists, frequently on different days of the week. Furthermore, in clinics attached to teaching hospitals, the system of rotating house staff results in lack of continuity in patient care. In this system, there is generally no single physician who is responsible for the total care of the patient and therefore little coordination among the physicians caring for parts of the patient's problem.

Such fragmentation of care is most pronounced—and most detrimental—in the care of the chronically ill. It can be especially detrimental in the care of a chronically ill child. The impact of chronic illness is often more serious on a young patient than on an adult, since in a child the illness coincides with important developmental changes. Moreover, responsibility for a child's long-term care rests not with him, but with his parents who are often burdened with the care of other children and so have difficulty in taking the child to several different clinics. In addition, when chronic illness occurs, particularly among the indigent, a cyclical process is initiated: The impact of long-term illness in the family often exacerbates many existing psychosocial problems that in turn interfere with the ability of parents to care adequately for their chronically ill child.

In an effort to attack some of these problems and to improve and coordinate the medical care of chronically ill children, the Sinai Hospital, a voluntary hospital in Baltimore, established a Family Pediatric Clinic in 1963. Initiated with a grant from the Thomas Wilson Foundation and now supported by

the Children's Bureau, the clinic's primary objective is *to provide family-centered pediatric care to families with a chronically ill child.* Recognizing the importance of the family as the basic social unit in providing medical care, the clinic offers total health care for all the children in the family as well as for the chronically ill child.

Since Sinai Hospital is a teaching hospital, another major objective of the clinic is to provide pediatricians in training with the kinds of experiences they are most likely to encounter in their future pediatric practice.

In recent years, there has been increasing concern over the inconsistency between the training that pediatricians receive during their hospital residency and the problems they subsequently encounter in caring for children in the community. The chief reason for this inconsistency is that today pediatricians in this country are being trained almost entirely at large university centers. Because these institutions attract many patients who have complex medical problems, the young physician's learning experience often is based primarily on unusual and esoteric cases and on relatively few of the more common conditions seen in practice. Such experience with complex medical problems is, of course, invaluable for understanding disturbed physiology. It sharpens the young physician's powers of observation, and develops an inquiring mind. However, as Dr. John Paul of Yale University said 15 years ago, "Sick people at hospitals are isolated specimens . . . segregated from their environment, removed from the circumstances from which they became ill, and separated from their families." Wrote Dr. Paul:

> All of [this] is done to create a proper atmosphere of diagnostic study and careful management on the physician's part, free of outside distractions. It may be trite to point out that these outside distractions are the very thing which the modern doctor needs to study, also. In order for us to handle patients accurately, it is necessary to bring clinical judgment to bear not only on the patient, but also on the circumstances under which his illness arose.[1]

Dr. Paul's comments have at least as much relevance today as when they were written. Moreover, the more scientific and the more automated the hospital centers become, the less emphasis is likely to be placed on teaching doctors the broad aspects of medical practice.

As a hospital resident, the pediatrician is naturally involved with the immediate illness. His contacts with the patient's family are brief. He rarely obtains an adequate family history and, therefore, has only a limited awareness of the family milieu and the social conditions to which the patient returns following discharge.

However, most pediatric patients never need admission to the hospital as inpatients. It is now generally acknowledged by medical educators that the pediatrician's training in care of the sick in the hospital must be supplemented by experience with ambulatory patients. But simply allocating more of the resident physician's time to a crowded, uncomfortable clinic or emergency room does not solve the problem because, unfortunately, the scope of training in many outpatient departments is still very narrow. Much of the teaching is carried out in a specialty clinic environment by pediatric subspecialists who, although experts in their particular fields, do not have the time for, or the interest in, the broader aspects of child and family care. Moreover, the system of scheduling the clinic physicians make it difficult for them to gain any long-term experience in guiding the physical and emotional development of children, in counseling in social and psychological problems, and in the use of community resources.

In recognition of these deficiencies, the American Board of Pediatrics has recommended an additional year of training for pediatricians, after the 2-year hospital residency, to be focused on problems of behavior, of school and family life, and of chronic and handicapping illness—training to be gained "in contact with other community health resources."[2]

With these considerations in mind, the Family Pediatric Clinic at Sinai Hospital has been organized to serve *as an active training and teaching instrument* for pediatricians in training, integrated with the total training opportunities provided by a community hospital for physicians as well as paramedical staff.

How the clinic operates

Families are admitted to the Family Pediatric Clinic if they meet the following qualifications: (1) the presence of a chronically ill child in the family; (2) evidence of medical indigency; and (3) residence in the census tracts that Sinai Hospital serves.

The clinic is directed by the hospital's assistant pediatrician-in-chief and is staffed by a pediatrician in training (family pediatric fellow), two part-time staff pediatricians, a public health nurse, a social worker, a clinical psychologist, and a speech therapist. Psychiatric services are available, when needed, from a part-time psychiatrist on the Family Pediatric Clinic staff.

The clinic differs in several respects from traditional hospital outpatient services. In the first place, it does not focus on any one chronic disease, organ, or particular condition. Chronic disease is not viewed primarily as a matter of classification, descriptive physical findings, or an array of laboratory tests, but rather as a handicapping condition that demands a careful assessment of the social, educational, and emotional impact on the child and his family. Moreover, the Family Pediatric Clinic is concerned not only with treatment of the illness, but also with the maintenance of health in the broadest possible terms. Its care begins with a health appraisal of *all* the children in the family by the resident physician, public health nurse, and social worker. Much of this care consists of preventive services. However, when acute illness does occur, care of the patient involves an appreciation of the effect of the illness on family function, rather than a limited disease-oriented approach.

An effort is made to select those cases in which a multidisciplinary approach to health care would appear to be most beneficial. These include families in which social problems seem likely to prevent successful medical management as well as families in which the chronic illness seems to be an intolerable burden added to already overwhelming social problems. Thus, prior to accepting a referred family into the program, the clinic staff surveys the medical, social, and emotional aspects of its problems by reviewing material from the referring clinic or social agency, by personal interviews, and by discussions in staff conferences.

In those families accepted for care, all medical care for the children, both in the clinic and at home, is provided by the family pediatric fellow. Regular clinic sessions meet four times weekly for scheduled appointments. In addition, the clinic is open for walk-in visits throughout the week. Night and weekend service is provided on a 24-hour basis by telephone and, when needed, by home visits. At least one scheduled home visit is made to each new family by the fellow, who makes subsequent visits, when needed, in times of acute illness.

Each clinic session is conducted by the family pediatric fellow and the public health nurse. The public health nurse makes a health survey of each new family through clinic interviews and a home visit. The parents in each family are seen by the social worker initially and as indicated thereafter. In the initial interview, the social worker, in talking with the parents for the purpose of social evaluation, describes the functions of the clinic to each new family and provides them with an instruction pamphlet for the patients, prepared by the staff.

The family pediatric fellow at the Sinai Hospital takes the blood pressure of a young patient whose brother looks on.

In providing complete medical care for all the children in each family, the family pediatric fellow becomes in essence the family pediatrician. Consultants in other specialties are called upon when needed. When this is done, the fellow is either present during the specialist's visit or in close communication with the consultant so that the specialist's recommendations can be integrated into a total health program for the family on a continuous basis.

Through his visits to the home, the fellow gains a firsthand impression of the environment. He develops a greater understanding of intrafamily behavior, learns to identify the areas of strength in each family, and becomes better able to counsel them in times of stress. In the day-to-day operations of the Family Pediatric Clinic, he works closely with the other members of the clinic's staff.

Through frequent discussions of specific problems, team members continuously reappraise their work with each family and coordinate their efforts. Thus, when family crises arise, as they frequently do in a clinic population, the physician is in a position to more effectively bring to bear the special skills of

the various staff members on a particular problem. For example:

The S family was admitted to the Family Pediatric Clinic because of a 5-year-old child with heart disease. During the long-term management of this family, a crisis developed when an older brother was taken to court because of truancy. Evaluation by the social worker and the psychologist revealed that this older boy's problem was one of school phobia that was being aggravated by disturbed interpersonal relationships in the family. This realization enabled the family pediatric fellow and other staff members to work constructively with the family and the school in trying to manage this child's problem.

Since the clinic places primary emphasis on the structure and function of families, the social worker plays a vital role in the clinic's work. In most of the clinic's families, health and social problems are closely entwined. Since the families come regularly to the clinic, the social worker has a satisfying opportunity to do casework over a period of many months and even years. She is able to evolve a deeper understanding of individual and family problems and thus determine whether patient and family can best be served by concrete casework assistance or by counseling. The social worker coordinates the efforts of other staff members in working with families and helps the members of the team to see the social implications of the medical problems that come to their attention. For example:

The M family came to the clinic's attention because of a young child who had been unsuccessfully treated for severe eczema in several hospitals. The intake interview by the social worker of the Family Pediatric Clinic revealed that the father had chronic alcoholism that had led to serious marital discord. The social worker's support of the mother in dealing with her husband's problem helped stabilize the home. This stabilization was accompanied by major improvement in the child's eczema that was not effected previously by medical therapy alone.

The public health nurse attached to the clinic provides both well-child and sick-care nursing during clinic sessions. She also sees each family at home initially and at regular intervals for followup as indicated. She helps to introduce many of the Family Pediatric Clinic's services to the patients and increases the effectiveness of the staff's recommendations by interpreting them to the families. She not only plays an important role in patient care by bridging the gap between hospital and home, but she also keeps the hospital's regular staff members and student nurses to increase their understanding of the effects of family and environmental factors on child development.

We have often found that apparently healthy brothers and sisters of the chronically ill child have medical and other kinds of problems, particularly in the areas of behavior and learning difficulties. These children, therefore, seem to represent a high-risk population to which more intensive medical services should be directed in all pediatric clinics that deal with chronically ill children. One example among many is the D family, which was referred to the Family Pediatric Clinic because of a child with pica and frequent respiratory infections. In examining the other children in the family the clinic found that an apparently healthy brother had primary tuberculosis and severe school problems as well.

The clinical psychologist has played a vital role in the program. Because of the frequency of behavioral and learning problems found in these families, many of our children require psychologic evaluation. The psychologist also counsels the parents about child-rearing practices that contribute to learning difficulties and also works with staff members from the schools in the area. In addition, he provides consultation to the family pediatric fellow, the public health nurse, and the social worker, all of whom also counsel parents in relation to child-rearing practices.

Regular staff conferences are held three times a week. They are designed to accomplish several objectives: (1) to consider and make decisions on prospective admissions; (2) to stimulate staff discussion in the direction of a unified family treatment plan; (3) to review periodically the impact and effectiveness of our service; and (4) to provide a forum for teaching. Teaching conferences are held for hospital and community personnel during which the health problems of one family are presented in great detail. These teaching conferences are in essence medical-social grand rounds for the hospital. They are attended by 30 to 40 people, including hospital staff

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Milton Markowitz, left, is director and Leon Gordis is associate director of the pediatric clinic they describe in this article. Both are also with The Johns Hopkins University School of Medicine, where Dr. Markowitz is associate professor of pediatrics and director of children's rheumatic clinics and Dr. Gordis is an instructor in pediatrics.

and student nurses, house officers, social workers, and community visitors. To demonstrate the value of using community resources in meeting the needs of children, key personnel from community agencies are often invited as discussants.

Experience to date

Thus far, the Family Pediatric Clinic has admitted over 80 families with a total of 250 children. Many of the families have been referred from the hospital's inpatient service, its regular pediatric clinic, or its pediatric specialty clinics. Patients have also been referred from the hospital's recently established genetics counseling unit as well as from outside the hospital—from schools, the courts, and the Division of Protective Services of the State Department of Public Welfare. In 1965, there were over 1,000 visits made to or by the family pediatric fellow, 893 in the outpatient department and 125 at patients' homes. This physician also participated in numerous telephone consultations.

Many of the families served by the Family Pediatric Clinic have undergone significant environmental changes since their admission to the program. Through the efforts of the clinic's social worker, some parents have secured job retraining and employment so that they have either already moved off the public assistance rolls or shown potential for doing so. Some have been helped to secure improved housing which has had a pronounced beneficial effect on the health of the chronically ill child, as well as on all the children in the family.

In addition to the benefits it provides directly to its patients, the Family Pediatric Clinic has provided a valuable educational experience in family-oriented care for its staff, especially for the pediatrician in training. The fellow has the opportunity to follow a number of families continuously during the 12-month period of his training in the clinic. Thus, he can not only watch the growth and behavioral patterns of children and the course of chronic illness, but also sense the development of his own relationship with these families. Because there is often a need to involve other agencies, he comes in close contact with other community resources, such as schools, the voluntary family service agency, and the local department of welfare. Though many of these resources are already well known to the social worker and public health nurse, for the physician it is an educational experience not usually otherwise obtained during his training years.

In addition to its educational effect on its own staff, the Family Pediatric Clinic has had a noticeable effect on the regular hospital staff not directly involved in its program, especially in the hospital's departments of pediatrics and psychiatry. Since the clinic's establishment, many of the hospital's clinicians and nurses have exhibited a new awareness of the social implications of disease. The clinic's weekly teaching conferences are well attended by the physicians, nurses, and social workers of the hospital's other clinics as well as by student nurses. An increasing number of referrals to the clinic are coming from staff members in other departments of the hospital.

While at the present time the Family Pediatric Clinic chiefly involves staff members from the hospital's departments of pediatrics and psychiatry, it is hoped that other departments in the hospital will participate in it as time goes on.

One of the great advantages of the program of the Family Pediatric Clinic is the fact that it is housed and operated in the regular outpatient department of the hospital. In this way, members of the medical and paramedical staff not directly associated with the program learn to consider it an integral part of the hospital's outpatient services rather than an extraneous project. Thus, the clinic's program has had

Case conference at the Family Pediatric Clinic. Left to right: family pediatric fellow, public health nurse, social worker, psychologist, and the associate director of the clinic.

a much more profound and extensive influence on members of the hospital staff than it could have had had it been separated in its own physical unit.

Problems and the future

One of the main operational problems confronting the Family Pediatric Clinic has been the provision of medical care to the parents of the children served. Since Children's Bureau funds are restricted to maternal and child care, it has been difficult for the clinic to provide the services of specialists in adult medicine, not only for the general preventive medical services needed by some parents, but also to care for their episodic illnesses. Such services have been made available by referring the patients to other hospital clinics, at Sinai Hospital or elsewhere, but the ideal of total comprehensive family medical care has not been realized.

Another major problem is presented by difficulties in interagency communication. Families with a chronically ill child often appeal to various community agencies for help with their complex social problems. In many communities, services are compartmentalized and, therefore, do not deal with the total family as an integrated unit. Since each agency sees only its part of the family problem and since communication between agencies is often inadequate, a family not infrequently receives conflicting, and at times diametrically opposite, advice from different sources. As a consequence, the parents of chronically ill children often become suspicious or completely alienated toward all health and welfare agencies.

During the past year, the Family Pediatric Clinic established close working relationships with several public schools in the hospital district. As a result, the family pediatric fellow, the psychologist, the social worker, and the nurse visit these schools frequently and confer with principals, teachers, and guidance counselors on specific cases as well as on general problems which are of mutual concern. Efforts to work closely with local community resources will be expanded this year. Nevertheless, there is need for considerable improvement in the clinic's communications with other agencies. For example, because caseworkers of the State Department of Public Welfare are burdened by enormous caseloads which preclude their going deeply into the many problems of the families they serve, they do not always collaborate with the clinic fully on all aspects of a family's problem. We have found, however, that having our weekly teaching conferences open to the staff of other community agencies has helped improve our working relationship with many staff members of the city welfare department and other community agencies in addition to stimulating referrals from them.

A question might be raised in regard to the feasibility of applying the Family Pediatric Clinic approach on a community-wide basis. We have been able to work intensively with our families because of the relatively small load of patients admitted to the clinic. Efforts to extend this type of care to the community at large inevitably must be restricted by both financial considerations and severe shortages of skilled professional personnel. Nevertheless, many of the principles involved in the Family Pediatric Clinic can be applied on a larger scale.

In fact, these principles *are* being applied in the new centers for the comprehensive health care of preschool and school-age children that are now being established in low-income areas of Baltimore by the Baltimore City Health Department and four teaching hospitals, with support from the Children's Bureau under a 1965 amendment to the Social Security Act.[3] Sinai is one of these participating hospitals, and two pediatricians who have been fellows in its Family Pediatric Clinic are now working in the comprehensive pediatric center which it administers under this program. Their experience in the Family Pediatric Clinic will be of great value in making this new project effective.

Our experience at Sinai's Family Pediatric Clinic demonstrates that total health care of the child extends into many areas outside the medical field, especially into the fields of public welfare and education. We believe that for such care to be optimal, the health provisions of all services should be coordinated under medical leadership. Moving beyond the hospital walls into a vital interest in all aspects of a child's life should not be considered a new departure for pediatricians, but rather an integral part of their commitment to child health care in its broadest sense.

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[1] Paul, J. R.: Preventive medicine at Yale University School of Medicine, 1940–49. *Yale Journal of Biology and Medicine,* January 1950.

[2] American Board of Pediatrics: Changes in training requirements for board examination. *Pediatrics,* May 1966.

[3] Social Security Act, Title V, Sec. 532.

an essay review . . .

a measuring rod for

JUVENILE AND FAMILY COURTS

MARGARET K. ROSENHEIM *Professor, School of Social Service Administration, University of Chicago*

Notable are the publications that, after 12 years in circulation, are deemed worthy of revision, rather than replacement. "Standards for Juvenile and Family Courts" * is in receipt of just such a prestigious distinction. It is an updated and slightly altered version of the 1954 "Standards for Specialized Courts Dealing with Children,"[1] and anyone acquainted with this earlier work can see why a thorough review by many experts resulted in a revision instead of a totally fresh effort.

The Children's Bureau has always had an active interest in the study of juvenile courts and the promotion of the best modern practices in these courts. Its concern has broadened over the years to include family courts. The title of the new "Standards" reflects not only inclusion of principles applicable to courts with a family-oriented jurisdiction, but also a bias in favor of their establishment. The document retains, however, an emphasis on the more ubiquitous juvenile court.

Perhaps it is important to specify what the new publication is not. It does not provide detailed exposition of the many vexing issues both juvenile and family courts confront. It does not propose particular legislative language—a task already undertaken by the National Council on Crime and Delinquency with the result that six editions of a Standard Juvenile Court Act were produced between 1925 and 1959. Nor does the "Standards for Juvenile and Family Courts" offer a summary of the laws and practices of the many juvenile courts, full and part time, in the United States.

The purpose of the publication is to expound the principles of juvenile and family courts and to set forth the procedures and practices endorsed by a group of experts as reasonable goals for all courts. Thus, it draws from what is best in the courts today and presents guidelines for tomorrow. In doing so, the publication aims at a diversified audience, not only judges and others in regular contact with the courts, but also "all persons interested in improving the juvenile and family courts of their communities." Therefore, it seeks to state the most important propositions for a wide readership rather than to go into detail and extended speculation.

The 1954 document was a groundbreaking statement in support of a modified due-process model of juvenile courts. It appeared at a time when a revival of concern for juvenile court operations was just under way, for in 1954—as compared with today—the number of knowledgeable critics and scholars studying this institution was small. Widespread critical interest had not yet developed.

By contrast, a bibliographical survey produced today would contain hundreds of items representing a diversity of professional perspectives and ranging from the various products of scholarship to documents hammered out in the heat of controversy. The past decade has been crammed with juvenile court materials, bespeaking a wave of interest in the various aspects of this institution unparalleled since the days of its founding. "Standards for Specialized Courts Dealing with Children" was a forerunner.

Today's "Standards for Juvenile and Family Courts" appears at a time when consensus has developed regarding most of the basic principles espoused in the earlier document. It appears, furthermore, at a time when the drama of the juvenile court movement has shifted from seminars and conference rooms to legislative halls and judicial chambers, including the Supreme Court of the United States. Thus, it should be reviewed for the basic soundness of the principles and recommended practices retained from the 1954 publication and of the modification or expansion of aspects that have, over the past 12 years, assumed significance.

I regard the principles in the 1954 "Standards" as largely sound. The new publication retains the basic ones—some in strengthened form. The significance of both versions is their clear endorsement of the practice of operating these specialized courts—whether juvenile or family—in conformity with the requirements of the rule of law. This calls for emphasis on the judicial character of the institution, but it does not preclude the use of qualified nonlegal professional practitioners whenever legal considerations are subordinate to social considerations.

Due process of law

As those familiar with either version of the "Standards" must realize, the implications of this commitment to due process of law are numerous and com-

*Sheridan, William H.: Standards for Juvenile and Family Courts. (Prepared in cooperation with the National Council on Crime and Delinquency and the National Council of Juvenile Court Judges.) Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 437. 1966. 130 pp. 45 cents. (For sale by the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402.)

plex. Police handling of juveniles, the function of family or juvenile court intake, the conduct of court hearings, the place of the specialized court within a large judicial structure—these and many other issues must be resolved in harmony with stated principles of individualized justice.

With informality a slogan of many juvenile court judges and their staffs, court hearings have in some jurisdictions more closely resembled case conferences than judicial trials. By 1954, it was beginning to be recognized that the price of informality was abandonment of certain values of traditional courtroom procedure. Critics cited the thoughtless departure from rules of evidence, the illogic of proving a juvenile's need for State supervision prior to, or even in lieu of, proof of jurisdictional requirements or the facts of an alleged act. They also cited the debasement of intentionally nonpublic hearings into summary private hearings at which the participation of persons with legitimate interests in a case—a counsel, a social agency representative, a schoolteacher—depended wholly on the sufferance of the judge.

In short, the proper protest against having the criminal court handle juvenile offenders, which had laid the groundwork in 1899 for rapid adoption of a specialized court for children, had resulted in sacrifice of the values of due process to a so-called casework or therapeutic intervention model. Many proponents of the virtues of juvenile justice had chosen to ignore the reality of authoritative imposition of rules, regulations, and even punishment and the stigmatizing effect of adjudication as a "delinquent."

Character of hearing

In 1954, "Standards for Specialized Courts Dealing with Children" issued an unmistakable policy pronouncement on the character of the court hearing. There should be "two separate parts which may or may not be continuous . . .":

1. The hearing of the evidence necessary to make a determination as to the court's jurisdiction and the facts alleged in the petition.

2. The hearing (if the court should find the child subject to its jurisdiction) of social evidence, including recommendations of the probation officer, culminating in disposition of the case.

The informality of the hearing, according to this policy, should not "mean that the court ignores rules of evidence or fails to establish procedures for its actions." The child's parent, other guardian of the person, or guardian *ad litem* should attend the hearing. Only after the facts alleged in the petition have been established should the court move to the second part of the hearing relating to disposition.

By these recommendations in 1954, the Children's Bureau squarely endorsed the principle of bifurcated hearings and certain essentials of due process—representation of the child's interest by some related or specially appointed adult, the right of parent or child to introduce witnesses and rebut evidence, and emphasis on the spirit (if not the legal letter) of procedural regularity. In doing so, the Bureau took a "harder" stand in favor of formality than was evident at the time in many courts, in the language of most juvenile court acts, or in the writings of other standard-setting organizations.

In the 1966 "Standards" a greater spelling-out of procedural details is apparent. This is hardly surprising: Consensus on the character of hearings (especially in contested cases) has grown in the 12-year interim and the experience with more formal procedure in specialized courts has produced questions, and demanded answers, on aspects of court operation previously seldom recognized. Evidentiary standards for court proceedings are now more fully stated; hearsay is inadmissible in the first part of the hearing and a requirement of "clear and convincing proof" of delinquency is imposed.

One earlier position is reversed. In 1954, the "Standards" stated: "No person in the court should assume the role of prosecutor." Now we are told:

No *staff member of the court* should assume the role of prosecutor. This follows from the noncriminal nature of neglect and delinquency proceedings. However, an attorney to represent the State, especially in contested cases, should be available to the court. This is necessary in order to prevent the judge from being placed in the untenable position of being a party to the proceedings. (Italics supplied.)

But, notwithstanding this procedural emphasis, the draftsman and consultants on the 1966 version justifiably retain their faith that the virtues of informality can co-exist with the requirements of order and dignity.

. . . It should not be forgotten that the real nature of the hearing will depend to a great degree on the ability of the judge and other court officials to convey the court's interest in the child and his family and to avoid expressions of disgust, blame, or anger, or indifference.

And, I would add, unless we find a way to cope with the volume of cases, the effort is doomed. Average hearing times of 7 to 10 minutes per case allow no room for "individualized justice"!

Some compromise

Necessarily, a standard-setting document reflects a consensus—which means compromise and complications for the reviewer. The 1966 "Standards" is not what I would have written; it is possibly not what its author or his consultants would have written individually. It is brief and general. In my opinion, it should be examined by the reader at arm's length—not to determine what particulars seem less than satisfying or have been omitted, but rather to discover the principles appearing in bold relief.

From this perspective the revised "Standards" amply meets the test of time. It clearly sets forth a philosophy, function, and procedures for the court in harmony with the goals of the juvenile court principle.[1] It offers counsel on the crucial matters of organization and administration, staffing, and community relations. It introduces the court novitiate or curious layman to the mysteries of a beleaguered but useful and exciting institution. And it lies to hand for the judge, his staff, and the citizenry in measuring the quality of local courts and proposing innovations. That it fails to answer all the questions of the experts or to hazard a reading of the future may leave some of us dissatisfied—but just until we realize that this is meant to be only the first cup of tea. Other cups are available, some of them with tea leaves at the bottom.

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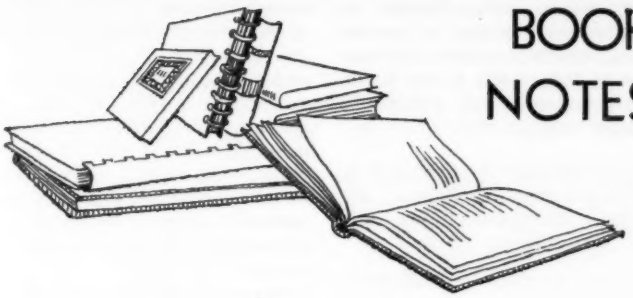
[1] Department of Health, Education and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.



BOOK NOTES

THE CHILDREN OF THE SOUTH. Margaret Anderson. Foreword by Ralph McGill. Farrar, Straus and Giroux Publishers, New York. 1966. 208 pp. $4.95.

Few people in Clinton, Tenn., expected serious trouble when their public high school was desegregated in 1956, according to the teacher-guidance counselor who is the author of this book. Speaking from her experience, she says of the first days of integration: "White students greeted . . . Negroes . . . in friendly and informal ways, as they had all their lives. A Negro girl was chosen to be an officer in her class." The school principal said to his staff: "If we can get through the first 2 weeks, we will be all right."

But Clinton did not get through the first 2 weeks without serious trouble. The author describes how outside agitators stirred up mob violence that eventually led to the destruction of a new high school and the need to call in the National Guard.

She also describes how after a new school was built the determination of the community leaders, school board, and school administration and faculty gradually moved the school from self-conscious desegregation nearer to true integration.

The major part of the book, however, focuses on the experience of "these pioneers of the 20th century—the Negro children who had the courage to face hostility, danger, and social isolation day in and day out in an effort to get a better education or to pave the way for others and on the difficulties they encountered not only because of the turbulent school climate, but also because of their background of poverty, the inadequacies in their elementary education, their low self-esteem, and the extreme pressures on them to succeed." The emotional toll is revealed in the words of the children themselves, as they poured out their feelings to their guidance counselor, the author.

In the last part of the book, the author discusses ways individual teachers in special educational programs might help close the educational gaps between Negro and white children.

Ralph McGill in his foreword says that this book reveals "what the costs of generations of segregation were, and are, to some 20 million Americans."

FREUD AND AMERICA. Hendrik M. Ruitenbeek. The Macmillan Company, New York. 1966. 192 pp. $4.95.

A distorted view of Freud's theories has influenced both child-rearing practices and education in the United States, the author of this examination of the effects of Freud's teaching in this country maintains. Child-rearing practices were the first to feel Freud's influence, he points out. Soon after World War I, "sophisticated parents," mostly those susceptible to fads, went overboard into permissiveness, ignoring "the stern realism with which Freud looked at human personality." Today, he contends, many children as well as parents are psychology conscious, and children often relate to their parents not only as parents but also as "peers" and sometimes as competitors.

He also attributes many of the failures of education in elementary and secondary schools to the dilution of Freudian theories and to the tendency of many teachers to act as though their chief function is to understand children rather than to help them acquire knowledge and to "learn to handle the intellectual tools which give them command . . . of their culture."

Diluted Freudian thought has also often made programs of psychological counseling in colleges ineffective, the author contends, and he recommends that universities apply psychoanalytic insight more effectively to help students "become more independent persons with more secure identities while they are acquiring their formal general education."

In other sections of his book, the author discusses the effects of Freudian thought and the works of his "forerunners and contemporaries" on religion and life in general in the United States.

THE SCHOOLCHILDREN: growing up in the slums. Mary Frances Greene and Orletta Ryan. Pantheon Books, a division of Random House, New York. 1966. 227 pp. $4.95.

Written by two elementary-school teachers, this book describes the day-to-day life of 4th-grade schoolchildren and their teachers in two New York City public schools, one in East Harlem, the other in Harlem.

The section on East Harlem describes a teacher's day—what it is like to teach culturally deprived children, some with severe emotional problems, and the reactions of the children to the teacher's authority and to the teaching program, which the authors see as inadequate and in many ways irrelevant.

The report on Harlem tells in the children's own words what they think of themselves, their homes, the school, and the world.

ON AGGRESSION. Konrad Lorenz. Translated by Marjorie Kerr Wilson. Harcourt, Brace & World, Inc., New York. 1966. 306 pp. $5.75.

The author, a scientist who observes animal behavior, describes the ways in which various kinds of animals handle their innate "intraspecific" aggression—aggression toward members of their own species—and shows how animal rituals that developed because of their survival value tend to become fixated and to be performed for their own sake. He then asserts that the same process has taken place in the cultural and phylogenic development of man, leaving man in the predicament of having ag-

gressive responses to rituals that not only no longer have survival value but also actually threaten the extinction of the species. He sees the only hope for mankind in an honest recognition of its aggressive instincts and their need to be discharged in some way—either destructively or harmlessly sublimated.

Implying that both the hope and the danger for mankind lie in youth's tendency to develop "militant enthusiasm"—a kind of "object fixation" that does not develop in later life—the author advocates that efforts be made to turn this "militant enthusiasm" toward art, science, medicine, and other interests based on humanistic values, rather than toward national and political causes. This directing, he maintains, cannot be done by education alone, but requires the development of a relation of trust and respect between the generations.

GROUP VALUES THROUGH CHILDREN'S DRAWINGS. Wayne Dennis. John Wiley & Sons, New York. 1966. 211 pp. $6.95.

Children draw what they admire and their drawings "represent social values," the author of this book maintains. On this assumption, he discusses and interprets over 2,500 drawings of "a man" by school boys from several ethnic groups and most socioeconomic levels in 13 countries.

Nearly all the drawings by boys in the United States, whether they were by white Christians, orthodox Jews, Indians, or Negroes, are of a similar figure—a young, well-dressed, smiling *white* man, the author says. One of his conclusions, therefore, is that these drawings strongly support "the idea that American culture manages to achieve a uniform set of values. . . ." On the other hand, he found that boys in Japan drew figures in Western clothes but with oriental faces, a fact he interprets to mean that they accept Western ideas but prefer their own faces.

Boys in Europe, the Middle East, and the Far East also tended to draw white men in Western clothes (though more Easterners drew men in native clothes than other groups), but their figures were less often smiling and more often suggested an occupation than those of the American boys.

The author believes his method of studying cultural values through the drawings of children can be used in both advanced and developing countries, but may be most useful in the latter. He is a psychologist and a professor at Brooklyn College.

BRIEF SEPARATIONS. Christoph M. Heinicke and Ilse J. Westheimer. International Universities Press, New York. 1966. 255 pp. $8.50.

Ten 2-year-old children studied by the authors of this report on the effects on young children of brief parent-child separation found it hard to reestablish an affectionate relationship with their mothers after separation of from 2 to 20 weeks. The investigators found that none of the children could respond at once to their mothers, though most quickly reestablished a relationship with their fathers. Some children were still hostile to their mothers 20 weeks after reunion. Partly because of this reaction, the authors speculate that it may be the function the parents perform rather than the person the child misses during the separation.

The purpose of the study, according to the authors, was to replicate and extend the findings of an earlier study they had conducted. In discussing the results of both studies, they include the results of studies on the same subject conducted by other investigators.

THE YOUNG NEGRO IN AMERICA: 1960–1980. Samuel D. Proctor. Association Press, New York. 1966. 160 pp. $3.95.

The Negro has moved through four stages from slavery toward freedom and is in his fifth, according to this discussion of the young Negro and his problems and prospects in the next 20 years. He has gone through social disintegration following the Emancipation Proclamation, alienation from the white man, imitation of the white man, and litigation to obtain his rights. Now, largely through the determined efforts of young Negroes, he is at the base of the fifth stage—integration.

The author maintains, however, that "The young Negro will have to remain committed to integration and not make a psychological nest inside the Negro world to which he may revert when the going gets rough," if the fifth stage is to be completed. He must compete with the white society in every way "to overcome his educational deficit, change the poverty pattern, and outlive the American stereotype of the Negro." Even under the most favorable conditions, the author asserts, the going will be difficult, and "nothing will resist him more persistently than the economic pressures in American life." He points to the necessity for the various segments of society to work together rather than against each other to effect needed change.

The author was until recently special assistant director of the Office of Economic Opportunity.

THE HAMPSTEAD PSYCHOANALYTIC INDEX: a study of the psychoanalytic case material of a two-year-old child. John Bolland, Joseph Sandler, et al. International Universities Press, New York. 1966. 203 pp. $4.50.

This monograph describes the case history of Andy, a young child with behavior problems treated at London's Hampstead Psychoanalytic Clinic. The point of the case presentation is to demonstrate how a psychoanalytic index developed at Hampstead can be applied to all cases and its value for research in psychoanalysis. For this reason, the book is divided into two parts. Part I contains Andy's clinical material; Part II follows, step by step, the indexing of the material, according to general case material, ego (general, anxiety, and defenses), instinctual aspects, object relations, superego, symptoms, and treatment.

READINGS FROM CHILDHOOD EDUCATION: articles of lasting value. Margaret Rasmussen, editor. Association for Childhood Education International, Washington, D.C. July 1966. 414 pp. $3.75.

Forty years (1924–64) of publication are represented in this anthology of more than 80 articles and poems taken from the journal *Childhood Education*. Selected from over 500 contributions, the articles are arranged under 6 headings: beliefs, the child, the teacher, the classroom, past inspirations, and future aspirations. Specific subjects include such topics as an adult's view of children's values; the role of love in preschool education; what creative teaching means; language in childhood; preparing children

for a world society; and the role of education in contemporary life.

A MONTESSORI HANDBOOK. Edited by R. C. Orem. G. P. Putnam's Sons, New York. 1966. 162 pp. $4.95.

This book contains Maria Montessori's own handbook on her teaching method and up-to-date material on Montessori theory and practice in the United States. Dr. Montessori's material is divided into five sections; each is accompanied by an introduction explaining in laymen's terms the content that follows and by essays discussing the subject-matter as applied today, written by representatives of medicine, education, and psychology. According to the editor, the book is intended for Montessori practitioners and nonprofessional readers alike.

FOUNDATIONS FOR MARRIAGE AND FAMILY RELATIONS. Dale L. Womble. The Macmillan Company, New York. 1966. 449 pp. $7.95.

Successful marriage is neither a "gift nor an accident," but, rather, a "hard-earned achievement," according to the author of this text on preparation for marriage and family life for unmarried college students. He sees marriage preparation courses as a means of helping college students develop "a basic philosophy about marriage and family relations" consistent with the goals of our democratic society.

The 21 chapters contain material on such topics as courtship, preparing for marriage, legal requirements, sexual harmony, mixed marriages, husband-wife relationships during pregnancy, rearing children, and understanding family counseling. Each chapter concludes with a summary and lists of questions "for further thought" and suggestions for further reading.

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films on child life

Charges for rental or purchase may be obtained from distributors.

CHILDREN IN THE HOSPITAL. 44 minutes; sound; black and white; borrow, rent, or purchase.

This film shows the behavior of 4- to 8-year-old normal children with acute medical problems in a city hospital as they react to the stress of hospitalization, illness, and temporary separation from their families.

Audience: Doctors, nurses, social workers, psychologists, and, with a professional discussion leader, undergraduate students, hospital volunteers, parent discussion groups, and selected lay groups.

Produced by: Edward A. Mason, M.D.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

THEY NEED THESE DAYS—DAY CARE FOR CHILDREN. 25½ minutes; sound; color; rent or purchase.

Describes a modern day-care program for 3- to 5-year-old children of working parents in a Minnesota community, pointing out the importance of providing preschool children with opportunities to learn and to develop healthy social relationships.

Audience: Inservice and preservice social workers, nursery school specialists, teachers, churches, intergroup organizations, and parents.

Produced by: James Liebling, University of Minnesota, for the Child Welfare Division, State Department of Public Welfare, St. Paul, Minn.

Distributed by: Audio-Visual Education Service, University of Minnesota, 29 Wesbrook Hall, Minneapolis, Minn., 55455.

THE PHENOMENA OF EARLY DEVELOPMENT. 13 minutes; sound; black and white; loan.

This film depicts the development of motor skills in a normal infant during three periods of infancy—3 to 6 months, 6 to 9 months, and 9 to 12 months. It is accompanied by an illustrated booklet with similar text which also discusses development in the infant's second year.

Audience: Instructors and students in child growth and development; persons conducting lectures or group discussions for nursing education, public health nursing, and medical student instruction.

Produced by: Ross Laboratories.

Distributed by: Ross Laboratories, Columbus, Ohio, 43216.

PKU—PREVENTABLE MENTAL RETARDATION. 15 minutes; sound; color; borrow, rent, or purchase.

This film illustrates through case histories the importance of detecting and treating phenylketonuria early in infancy to prevent mental retardation. It documents the progress of selected patients by repetitive sequences obtained at various times in their lives from 6 weeks to 3½ years of age. In addition, it presents general data about the disease concerning the signs and symptoms that suggest its presence.

Audience: Nurses, public health workers, physicians, and parents.

Produced by: International Film Bureau, Inc.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

A NEW LIFE FOR JENNIFER. 27 minutes; sound; color; loan.

Depicts the work of the Detroit Lutheran School for the Deaf in helping deaf children to lip-read, to speak, and to acquire a language foundation necessary for meaningful communication and learning.

Audience: Parents, religious organizations, and professional persons interested in or working with deaf children.

Produced by: Portafilms, Drayton Plains, Mich.

Distributed by: Lutheran School for the Deaf, 6861 East Nevada Avenue, Detroit, Mich., 48234.

HERE and THERE

Federal legislation

On November 3, the President signed into law amendments to the Elementary and Secondary Education Act of 1965. In addition to making some administrative changes, the amendments authorize:

- A new program of grants to the States for **education of the mentally and physically handicapped,** to supplement and increase, but not supplant, the level of State, local, and private funds expended for this purpose. Appropriations of $50 million and $150 million are authorized for this program for fiscal years 1967 and 1968 respectively.
- **Aid to schools operated by the Bureau of Indian Affairs** and to local educational agencies for the education of out-of-State Indian children, through funds allotted by the Commissioner of Education to the Secretary of Interior.
- **Inclusion of children in foster homes and institutions** for neglected and delinquent children in the child population counts on which payments to the States and local educational agencies are based under title I of the act (provisions for aid to school districts containing concentrations of low-income families).

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The Demonstration Cities and Metropolitan Development Act of 1966 was also signed by the President on November 3. Among other provisions, the act authorizes the Secretary of Housing and Urban Development to make grants and provide technical assistance for:

- **Comprehensive demonstration programs in cities** of all sizes "to rebuild or revitalize large slum and blighted areas; to expand housing, job, and income opportunities; to reduce dependence on welfare payments; to improve educational facilities and programs; to combat disease and ill health; to reduce the incidence of crime and delinquency; to enhance recreational and cultural opportunities; to establish better access between homes and jobs; and generally to improve living conditions for the people who live in such areas. These objectives are to be accomplished through "the most effective and economical concentration and coordination of Federal, State, and local public and private efforts." Grants are to be made to comprehensive city demonstration agencies of up to 80 percent of the costs for planning, developing, and administering the programs. The law authorizes appropriations of $12 million in planning funds for each of the fiscal years 1967 and 1968, and $400 million for fiscal 1968 and $500 million for fiscal 1969 for carrying out the program.
- **Assistance to planned metropolitan development projects** in the form of supplementary grants to State and local public bodies already engaged in such projects, not to exceed 20 percent of the cost. Appropriations authorized are not to exceed $25 million for the fiscal year 1967 and $50 million for fiscal 1968.

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Another act signed by the President in early November provided the District of Columbia with a **mandatory reporting law in relation to child abuse.** The law requires physicians and hospitals in the District to report cases of suspected physical abuse of children under 18 years old to the police department and provides for immunity from liability to judicial proceedings for the reporting persons or institutions.

With this law, the District joins the 49 States having laws to encourage the reporting of child abuse. Hawaii is the only State with no abuse reporting law.

Health manpower

The Nation's hospitals need 20 percent more professional, technical, and auxiliary workers than they now have if they are to give optimum service to patients, according to the findings of a recently completed survey carried out jointly by the American Hospital Association (AHA) and the U.S. Public Health Service (PHS). On the basis of their findings, the two agencies estimate that hospitals now employ 1.4 million professional and technical workers and need 275,000 more to provide optimum patient care.

The agencies found the following: The most urgent need is for professional nurses—hospitals need about 83,300 more than they now employ. Next greatest need is for nursing aides, orderlies, and attendants—about 48,700 more in general hospitals and another 31,300 more in psychiatric institutions. And the next need is for about 42,800 more practical nurses and about 6,400 more social workers than the 12,100 they now employ.

These estimates are based on data from 4,600 of the 7,100 hospitals registered by AHA. A complete report on the study will be available in the next few months.

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Two conferences on the potential place of midwifery or nurse-midwifery in obstetrical programs in the United States took place last fall. The first, held in Princeton, N.J., on October 24–25, was under the sponsorship of the Josiah Macy, Jr. Foundation and brought together about 25 specialists in obstetrics, pediatrics, maternity nursing, nurse-midwifery, and demography from the United States and other countries. At this conference it was pointed out that the United States was the only leading country in the world where midwives are not used extensively in medical care. One focus of the discussion was whether or not the more extensive use of midwives could help reduce the high infant mortality rates in some parts of this country or alleviate the severe shortages in health manpower. No consensus in viewpoint emerged.

The second conference on the subject was the third nursing roundtable sponsored by Ross Laboratories and was

held in Columbus, Ohio, on November 7. Ten maternity nurses and nurse-midwives from universities and professional organizations attended. With the purpose of initiating a dialogue between the two specialities represented, the participants presented papers giving an overview of maternity nursing and nurse-midwifery in the United States and discussed differences in points of view separating the two groups. The chairman was Edith Anderson, consultant in nursing education for the Children's Bureau.

Full proceedings of both conferences will be published soon by the sponsoring agencies.

Juvenile delinquency

In 1965 about 697,000 juvenile delinquency cases, excluding traffic offenses, were brought before the Nation's courts, according to Children's Bureau estimates based on data received from reporting courts. This number represents an increase of 2 percent over the previous year. In the same period, the number of children aged 10 through 17 increased only 1 percent. This continues the upward trend in juvenile delinquency cases that has prevailed since 1949, a trend broken only in 1961. Altogether, between 1957 and 1965, juvenile delinquency cases increased 58 percent—almost double the increase in the population of children aged 10 through 17 during the same period.

Most of the overall increase in 1965 over 1964 was accounted for by an increase in cases involving girls. These went up 8 percent during the year while the number of cases involving boys remained comparatively stable. However, as in past years, four times as many boys as girls were brought to court, and for different reasons. Boys were referred most often for offenses against property; girls, for misbehavior such as running away and "ungovernable behavior."

A 12-percent decrease in juvenile delinquency cases occurred in 1965 in courts in rural areas. This decrease, however, had little effect on the overall trend since urban courts handle more than two-thirds of all delinquency cases in the country.

The number of traffic offenses handled by juvenile courts also increased in 1965, by 4 percent. In rural courts, the increase in traffic cases was 19 percent. In all, city and rural courts handled about 460,000 traffic cases involving 397,000 different children.

The courts also handled an increased load of dependency and neglect cases in 1965—157,000 cases, or 5 percent more than in the previous year.

These data and other statistics on children's court cases are presented in the publication "Juvenile Court Statistics—1965" (CB Statistical Series No. 85), issued by the Children's Bureau. Single copies may be obtained without charge from the Bureau.

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More than 900 adults in contact with juvenile delinquents because of their "position" as fathers, mothers, teachers, policemen, or probation officers defined their own and each others' roles in the prevention of juvenile delinquency in different terms when questioned by researchers at the Youth Studies Center of the University of Southern California for a recent study, conducted by Alexander W. McEachern and Edward M. Taylor, with support from the Children's Bureau. The adults surveyed agreed that parents have the prime responsibility for preventing delinquency, but they did not agree on what adults in each category of position should do or actually do in specific situations or on what might be an effective action.

Each of the adults queried was in one of the five authoritative positions in relation to a sample of 259 juveniles referred to probation departments in Southern California. They were asked to give their opinions of specific adult actions toward children involving three types of adult behavior—physical manipulation, transferral of information, and demonstration—in relation to whether the actions were appropriate, actual, or effective behavior for an adult in their own position and for adults in the other four positions.

In each category of adults, a lack of consensus was found not only in relation to the appropriate, actual, or effective behavior of adults in the other categories, but also in relation to the respondents' own category. However, the differences were more marked between positions than within them.

Such disagreements in the way adults see adult behavior toward juveniles, the investigators conclude, seem to arise more from differences in the institutions the adults represent than from differences in personalities; nevertheless they result in confusing inconsistencies in expectations and goals for young people.

The investigators recommend that society set up general expectations for each role the child must take and not concentrate on problems that arise when a child does not meet the expectations different kinds of adults have for him.

Handicapped children

An analysis of consonant sounds produced by persons with oral clefts can be used to show a wide range in their speech ability, to determine the details impairing intelligibility of their speech, to evaluate changes in speech following treatment, and to compare their speech with the speech of normal persons, according to a study recently completed by the Department of Speech and the Speech Clinic at the University of Michigan. The study was conducted by T. David Prins and H. Harlan Bloomer with a research grant from the Children's Bureau.

The investigators analyzed the speech of 20 boys with oral clefts, aged from 9 to 18, enrolled in a residential program of speech therapy. As part of the study, each boy made a sound recording of a 50-item word list before and after treatment. While listening to the recordings, untrained listeners wrote down either the entire word they thought they had heard or its initial consonant. Although individual listeners varied considerably in responding to identical word lists on different occasions, the listeners as a group showed good stability in scores representing mean percent of error, the distribution of error across phoneme classes, and the type of error as a function of phoneme class.

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Four new research projects on handicapped children are included in recent awards made by the Children's Bureau for research in maternal and child health:

- University of California at Los Angeles, to study the use of a response computer in testing deafness in infants before they are old enough to respond to standard tests ($16,690).
- University of Washington, Seattle, to study the effectiveness of a multidiscipline team method in providing services to patients in clinics for handicapped children ($52,142).

• American Institute for Prosthetic Research, to study a pneumatic arm prostheses ($65,621).

• University of Illinois-Chicago Medical Center, to develop a research design for studying children with multiple handicaps ($76,798).

Against rubella

A test by which a physician can tell within 3 hours whether a patient is immune to rubella (German measles) was recently released to hospitals, public health departments, and diagnostic laboratories by the developing agency, the National Institutes of Health (NIH), U.S. Public Health Service. Scientists at NIH report that the test is simple, fast, sensitive, reliable, and inexpensive and that it can be used to detect whether or not immunity exists even years after infection.

The new test, called hemagglutination-inhibition (H–I), is expected to speed up the development of vaccines against rubella now under study at NIH and in private laboratories. If so, a vaccine may be available within the next 3 years—before the expected appearance of another rubella epidemic such as the one in 1964, which impaired the development of about 20,000 unborn babies of women who contracted the disease in pregnancy. With the new test, researchers can determine more rapidly than with earlier tests the effectiveness of experiments with attenuated virus preparations, with which they are now working.

NIH scientists also point out that the new test can now be used on pregnant women who have been exposed to rubella to determine whether there is cause for concern or whether the patient is immune to the disease and her unborn child therefore at no risk; and that after the vaccine has been developed, women can be tested before marriage and inoculated against rubella if they are not already immune.

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During the first year of a 5-year special project begun in 1965 on the effects of rubella contracted before birth, the Baylor University College of Medicine found that infants showing the symptoms of congenital rubella can be diagnosed positively as having been infected with the disease and that the resulting impairment can be distinguished from congenital impairment from other causes. Such symptoms include defects in vision and hearing; retardation in adaptive ability and in motor and language development; cardiac disease; and low birth weight.

The project has coded information on 96 infants, most of whose mothers contracted the disease in the epidemic of 1964. The infants showed the following specific effects: 26 had defects in vision and hearing; 9, defects in vision only; 33, mild or severe hearing defects only; and 71, cardiac disease. In addition, the birth weights of most were low, and 25 percent were still harboring rubella virus at 12 to 15 months of age. Of 126 infants originally selected for study, 20 died during the first year.

During the second year of the project, now in progress, the researchers will continue to follow the natural history of the disease and to provide medical services to these children. In addition, they are working toward developing an experimental model program using medical and community facilities for 150 children born with the symptoms of rubella. Of these children, the researchers expect that 98 will have defects of hearing; 44, defects in both hearing and vision; 90, defects in vision only; and 108, cardiac disease.

The project is receiving Federal support through a grant from the Children's Bureau.

Infant mortality

A recent investigation by the Children's Bureau, in cooperation with the Maternal and Infant Health Computer Project at George Washington University, of infant mortality levels in the more than 3,000 counties in the United States in the 5-year period 1956–60 revealed that 90 percent of the counties had infant death rates in excess of 18.3 per 1,000 and 10 percent had rates of 18.3 or lower. On the basis of these findings, the Bureau has estimated the number of "excess infant deaths" for each of the higher rate counties. The excess number was defined as the difference between the actual number of infant deaths in the county and the expected number if the 10th percentile rate—18.3 deaths of infants under 1 year per 1,000 live births—had held.

This analysis indicated that during the 5-year period 169,784 infant deaths occurred in the United States in excess of what would have occurred had the 10th percentile rate prevailed. Well over one-third of these excess infant deaths were concentrated in 56 counties, nearly all of which were metropolitan. On the other hand, counties with infant death rates as low as or lower than the 10th percentile county rate were with few exceptions without urban areas with populations as large as 50,000.

Inservice training

"Meeting the Needs of Children Through Social Services," a series of 12 films and guides for discussion leaders used in South Carolina last year as part of an inservice training program for public welfare workers is now available from the Department of Film Services at the University of Tennessee (Knoxville). Both the films and guides were produced jointly by the University of Tennessee School of Social Work, the South Carolina Department of Public Welfare, and the South Carolina Educational Television Network. The project was supported in part by a child welfare training grant from the Federal Children's Bureau.

The films run for 30 minutes each. They illustrate such topics as social development in children, professional casework relationships, interviewing, and helping one-parent families. The guides were prepared for persons selected to lead discussion groups after a viewing of the films.

The films were telecast last year, once a week, over South Carolina's closed-circuit television system to all county social service staff members. Trained leaders led the ensuing discussions.

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Under a 2-year career development program, four recent graduates of schools of social work are now working with the Bureau of Family Services of the U.S. Welfare Administration as interns in public welfare administration. For the first year they will be attached to the central office in Washington, D.C., and are now on assignments in the Bureau's Division of Program Operations. For the second, they will be assigned either to a division in the central office or to one of the nine regional offices according to fields of interest, positions available, and geographic preference. During their

internship they will have opportunities to work with State and local public welfare agencies and opportunities for field experience as needed.

The Bureau expects eventually to have openings for 6 to 10 interns each year and plans to select candidates again next spring. Though it does not require applicants to have professional experience, it will give preference to those who do have experience, and it does require the intern to have a master's degree in social work by the time he comes on the job.

At the end of the 2 years, the interns will be ready to enter careers in some field of public welfare administration.

Child welfare services

On March 31, 1965, about 697,300 children were receiving services from public and voluntary agencies and institutions, the greatest number on record, according to reports received by the Children's Bureau. This represented a 7-percent increase over the number being served on the same date the previous year.

Of these children, 69 percent were being served primarily by public agencies and institutions; 31 percent, by voluntary. About 42 percent were living with parents or relatives; 30 percent, in foster family homes; 16 percent, in institutions; 10 percent, in adoptive homes; and 2 percent, under other kinds of arrangements.

The greatest increase was in the number of children served by public welfare agencies: an increase of 29,000 children, or 13 percent, in their own homes; of 16,800, or 8 percent, in foster care; and of 2,900, or 9 percent, in adoptive homes. The services of voluntary agencies rose substantially only for children being served in adoptive homes: 2,100 children, or 7 percent, more than on the reporting date in 1964.

For a fuller analysis of child welfare services, facilities, expenditures, and personnel, see "Child Welfare Statistics—1965" (CB Statistical Series No. 84). Single copies are available from the Bureau without charge.

COMPARATIVE INFANT MORTALITY

Country	Rate per 1,000† 1962–64	Percent change 1962–64 from 1961–63
Sweden	15.0	−3.2
Netherlands	*15.8	−4.8
Norway	*17.1	−3.9
Finland	*18.5	−6.6
Denmark	*19.3	−4.9
Australia	19.7	−0.5
New Zealand	19.7	−5.8
Switzerland	20.2	−3.4
United Kingdom	*21.6	−2.3
Japan	23.3	−10.4
United States	25.1	−0.8
Canada	26.1	−3.3
Federal Republic of Germany	*27.1	−7.2
Ireland	*27.5	−4.2
Luxembourg	29.5	+3.1

†Deaths of infants under 1 year per 1,000 live births
*1964 data provisional
Source of data: Demographic Yearbook, 1964, Statistical Office of the United Nations, New York

The United States infant mortality rate in the 3-year period 1962–64 ranked 11th in a selected group of 15 countries. These are countries with advanced economies, with populations (1960) of at least 300,000, and with well-developed vital record systems, conforming to the World Health Organization's definitions. Among the same countries, the U.S. rate for the period 1961–63, as well as in 1960, was in 10th position as compared with 6th in 1950.

The apparent shift in position of the U.S. rate results from faster pace of reduction of infant mortality in other countries; for example, between the two periods (1961–63 and 1962–64), about a 10-percent reduction in the infant death rate was accomplished in Japan while for the United States the decrease was under 1 percent. Other countries, with rates already lower than that of the United States, made more rapid decrease.

—Eleanor P. Hunt

Foster care

Between March 31, 1961, and the same day in 1965, the number of children under 18 years old in foster care under public or voluntary agencies rose from 246,500 to 287,200, according to a recent Children's Bureau analysis of figures received from the States. If the increase continues at this pace, by 1975 about 364,000 children under 18—4.7 per 1,000—will be in foster care of some type.

The figures show that in recent years the number of children in foster care under agency auspices has steadily increased, following a period of decline. The number dropped after 1933, and the level for that year was only reached again in 1961–62. The rate of foster care also dropped substantially after 1933, but it has slowly risen in the last several years. The rate for 1965 is two-thirds of the 1933 rate. If the rate prevailing in 1933 had continued, an additonal 136,000 children would have been in foster care in 1965.

Since 1933 and 1950, there has been a decided shift from institutional to foster family care. On March 31, 1965, about 207,800 children under 18—or 2.9 per 1,000—were in foster family care as against 79,400, or 1.1 per 1,000, in institutional care. Those in foster family care were for the most part (78 percent) under the care of public agencies; those in institutional care for the most part (86 percent) under voluntary agencies.

Foster care under public auspices, in terms both of number and rate of children in care, has risen consistently

since 1933; at the same time, foster care under voluntary agencies or institutions has decreased, the number of children in voluntary care in 1965 being 36 percent below the 1933 level.

Statistical tables and a more detailed analysis are available in the recent publication "Foster Care of Children: Major National Trends and Prospects," prepared by Seth Low. Single copies are available on request from the Children's Bureau.

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The Wurzweiler School of Social Work, Yeshiva University, New York, in its 1966–67 winter session is conducting a pilot project in the training of foster parents. The foster parents will be selected by the public and voluntary agencies in New York City.

The emphasis will be on child growth and behavior and on the special development of the relationship between parent and foster child.

Courses for three groups of foster parents will be held at the university. Each group will consist of eight foster-parent couples. Two will be for one semester and one for two semesters. The plan also provides for prior and post-training sessions for agency supervisors and caseworkers to increase their effectiveness in ongoing agency training of foster parents.

The purpose of the project, which is supported by a training grant from the Children's Bureau, is to demonstrate a pattern for the collaboration of child-placement agencies and schools of social work which might be adopted elsewhere.

Adoption

Parents who adopt a child over 5 years old appear to run little more risk of having the adoption fail than those who adopt younger children, according to a study recently completed by the University of Wisconsin School of Social Work, under the direction of Alfred Kadushin. The project was largely supported by a grant from the Children's Bureau. The 4-year study of 91 children adopted after they were 5 (but before they were 12) and their adoptive parents found that over three-fourths of the parents were satisfied with the adopted child, though most of them had originally wanted younger children.

Most of the children involved in the study came from homes in which they had been badly treated and from which they had been removed by court order. To cut down the variables, the study considered only white children with normal physical and mental health. All of the adoptive parents were from higher socioeconomic levels than the natural parents, and most were older than the parents who usually adopt infants.

The study found that much of the success of the placement rested on the degree to which the parents accepted the adopted child and that many of the children showed a "biological resiliency" that helped them make wholesome responses to a change in environment.

Nutrition

About 70 public health nutritionists and dietitians from 27 States attended a 4-day workshop in Kansas City, Mo., in early October, on nutrition services in maternity and infant care projects and comprehensive health services for children and youth. Sponsored by the Children's Bureau and the Division of Health of the Missouri State Department of Public Health and Welfare for the States covered by Regions I, II, V, VI, VIII, and IX of the Department of Health, Education, and Welfare, it was the first of two national workshops planned to improve and extend nutrition services in such projects. The second will take place in New Orleans in February.

The discussions focused on such questions as: the main nutritional factors contributing to a high-risk pregnancy; current knowledge of nutritional requirements during pregnancy and ways of meeting these needs on a subsistence income; nutritional needs of the pregnant adolescent girl and ways of motivating adolescents to accept a nutritionally adequate diet; the problem of iron deficiency anemia in infants; the dangers of overnutrition (caloric) in relation to weight gain and growth in infants and young children; and methods of interviewing, reaching subcultural groups, keeping appropriate clinical records, and preparing reports on nutrition.

A 3-member panel of nutritionists from maternity and infant care projects in Minneapolis, Minn., Portland, Oreg., and Cincinnati, Ohio, described a nutritionist's role in a multidisciplinary team; coordination of nutrition services with other community programs such as public assistance and the food stamp plan; and the use of home economists in training neighborhood leaders as nutrition aides to teach small groups of mothers.

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Among recent grants for research in the field of maternal and child health made by the Children's Bureau were three to support new research on nutrition. The three grants were awarded to:

- Children's Hospital Research Foundation, Columbus, Ohio, for a study of malnutrition among children from 1 to 6 years old in low socioeconomic areas ($159,860).
- Michael Reese Hospital, Chicago, Ill., for a study of intra-uterine malnutrition ($36,930).
- The Food and Nutrition Board, National Academy of Sciences-National Research Council, Washington, D.C., to consider special problems in current maternity and infant care programs and to develop up-to-date guidelines for providing nutrition in maternal health.

Education

About 56 million children and young people were enrolled in public and private schools and colleges in the United States last fall—a 2.6-percent rise over 1965—if estimates made last summer by the U.S. Office of Education hold true.

The largest proportion increase was expected to be in colleges and universities: 6 million, or 9.1 percent, over fall 1965. High school enrollment (grades 9 through 12) was expected to rise to 13.3 million, an increase of 2.3 percent; grade school enrollment (kindergarten through grade 8) to 36.6 million, an increase of 1.7 percent.

To teach these students, the Office of Education estimates colleges and universities need 466,000 instructors, 8.6 percent more than last year; grade and high schools, 2,045,000 teachers, 4.1 percent more than in the previous year.

In the 1966–67 academic year, the schools are expected to spend about $48.8 billion as against $45 billion spent in the fiscal year 1965–66. In the latter year the Federal Government contributed $6.1 billion in grants to schools at all grade levels, more than 2½ times the Federal contribution in 1963–64.

These and other figures are contained in two forthcoming publications of the Office of Education: *Digest of Educational Statistics* and *Projections of Educational Statistics*. According to the *Digest*, more than 70 percent of the young people in this country who are in their 20's have had a high school education.

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Elected by their fellow villagers for training as teachers for Project Head Start, 50 Alaskan "natives"—Eskimos, Aleuts, and Athapaskan Indians—are presently serving as teachers in programs for preschool children set up in their villages. None of them had taught before, and several have had no more than a fourth-grade education; but all were chosen as persons who work well with children.

Before taking up assignments with Project Head Start, the 50 prospective teachers completed an 8-week training course at the University of Alaska in subjects preschool teachers need to know about such as nutrition and arts and crafts. Teaching supervisors will visit each village project regularly to help these teachers improve their competence.

Last year, the Alaska State Community Action Program was unable to fill the demand from village councils for help in establishing preschool programs because of the lack of preschool teachers in the area. Through the new program, about 35 village projects were set up this past fall.

Rehabilitation

A national Commission on Accreditation of Rehabilitation Facilities was established last July by the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) to develop improved standards for rehabilitation facilities. The commission consists of a nine-member board of trustees: three each from ARC and NASWHP and three chosen at large by the other six members.

The specific objectives of the commission are: (1) to promote and assist in the self-improvement of rehabilitation facilities by providing educational and advisory services; (2) to adopt standards for measuring rehabilitation facilities for accreditation; (3) to publish lists of rehabilitation facilities meeting the commission's standards; and (4) to promote and conduct studies that will improve the initial standards.

The plan is endorsed by the U.S. Vocational Rehabilitation Administration.

Correction

In Van G. Hromadka's article, "Toward Improved Competence in Child-Care Workers: 1. A Look at What They Do" (CHILDREN, September–October 1966), the inadvertent omission of a "not" from a sentence describing one criterion for selecting the 12 institutions under study unfortunately reversed the facts. The sentence beginning at the bottom of the first column on page 181 should have read: "A major basis for selection was that the institution had not less than 30 percent of its population under clinical treatment for emotional disturbance. . . ."

guides and reports

HELPING CHILDREN IN INSTITUTIONS: a report on 26 courses for child care workers. Eva Burmeister. Federation of Protestant Welfare Agencies, 281 Park Avenue South, New York, N.Y., 10010. 1966. 51 pp. $1.

Describes and evaluates the basic and advanced courses for institutional child-care workers in the New York area conducted from 1957 through 1964 under the auspices of the Hunter College School of Social Work and the Federation of Protestant Welfare Agencies.

EARLY CHILDHOOD: crucial years for learning. Margaret Rasmussen and Lucy Prete Martin, editors. Association for Childhood Education International, 3615 Wisconsin Avenue NW., Washington, D.C., 20016. 1966. 89 pp. $1.25.

Contains reprints of 22 articles from *Childhood Education* on the relation of nursery school and kindergarten education to the intellectual and social development of young children.

DIRECTORY OF MATERNITY HOMES AND RESIDENTIAL FACILITIES FOR UNMARRIED MOTHERS: a guide for use and selection. National Council on Illegitimacy, 44 East 23rd Street, New York, N.Y., 10010. May 1966. 206 pp. $4.50. Discounts on quantity.

The first revision of this directory since 1960, this edition includes in addition to brief descriptions of traditional maternity homes, lists of the other types of facilities they use—foster family homes, mutual service or wage homes, and group homes.

HELPING HANDS: volunteer work in education. Gayle Janowitz. University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill., 60637. 1966. 125 pp. $1.75 paperback; $3.95 cloth-bound.

A guide for the organization and operation of afterschool study centers for underachieving children and the use of volunteers as tutors, based on experience in a tutorial project financed by the U.S. Office of Education.

STANDARDS AND GOALS FOR METHODIST AGENCIES SERVING CHILDREN AND YOUTH. Board of Hospitals and Homes of The Methodist Church, 1200 Davis Street, Evanston, Ill., 60201. 1966. 83 pp. $1.50.

The second revision of a publication originally issued in 1956.

IN THE JOURNALS

Service and aid

The goal of the social reformers of the early 1900's who worked for the establishment of a Children's Bureau in the Federal Government to integrate "*all* public services and aid for families and children of all classes" was lost sight of in the 1930's when new financial aid and service programs were put under separate administrations by the Social Security Act, writes Archie Hanlan in the November 1966 issue of *Child Welfare*. ("From Social Reform to Social Security: The Separation of ADC and Child Welfare.") Presenting a historical account of the creation of the Bureau in 1912 and of the events that preceded the enactment of the Social Security Act in 1935, he asserts that the unifying role envisioned for the Children's Bureau became obscured by the pressures to meet the economic crisis. The multiplication of Federal programs in recent years has made the need for relating aid to service programs more urgent than ever, he says.

Maintaining that there is a silence among social workers today in comparison to their vocal espousal of an integrated Federal aid and service program in the early 1930's, he attributes this silence to skepticism toward the "sudden wooing of the poor." Even if a unified aid and service program came about "at this late date," he fears that it will only mask "society's failure to come to grips with poverty in the midst of affluence."

Stability in delinquency

One reason why studies on the use of the casework method in working with juvenile delinquents indicate such poor results may be that society tends to push the young person who commits delinquent acts into a "stable role" as a delinquent, William P. Lentz maintains in the October 1966 issue of *Social Work*. ("Delinquency as a Stable Role.") He points out that everyone around the young person who commits a delinquent act—parents, friends, teachers, policemen, and social workers—whether they are sympathetic or disapproving, treat him as a delinquent, and that the caseworker is, therefore, at a disadvantage in trying to set up a one-to-one relationship.

Accepting this fact—that the social climate tends to push the young person into a "stable role" as a delinquent—may help social workers reshape their efforts, the author suggests. It is his contention that if the system does not change—and he sees no change in the offing—improvement in the results of casework is not likely. He concludes, therefore, that the problem of "role stability" will continue to hinder efforts to help young people who commit delinquent acts until agencies are able to minimize the "situations that contribute to the development of the stable role" and to lend their support to "proposals that will lead to change."

Effects of hospitalization

Reporting in the October 1966 issue of the *American Journal of Orthopsychiatry* on the preliminary findings of a study of the effects on families of the hospitalization of parents in a mental hospital, Elizabeth P. Rice and Sylvia G. Krakow point out that, though the families studied faced many problems in child care, few tended to call on community agencies at the time of admission. ("Hospitalization of a Parent for Mental Illness: A Crisis for Children.") However, they report, these families seemed to welcome help from community agencies when it was offered.

The study was conducted at a State mental hospital in Massachusetts using 40 patients and their families as demonstration cases and 59 patients and their families as control cases. Demonstration families were assigned to agencies for continuing services; control families were given no special attention.

The problems in child care were greater when the patient was the mother and when the children were very young, the authors report. In some cases, the return of the patient to the home brought on additional problems if the mother was not ready to take on her duties. Homemaker services proved valuable in supporting both relatives caring for children and parents.

The authors maintain that the study demonstrated the "value of having a social worker at the point of admission to refer families with child-care problems to appropriate community agencies" and that "additional methods and skills appear to be required to achieve adequate protection of children with mentally ill parents either at home or in the hospital."

Migrant children

The greatest service the physician working with the children of migrant farm families can do for migrant children is to stimulate his community to act on their behalf, writes Earle Siegel, M.D., in the October 1966 issue of *Clinical Pediatrics*. ("Migrant Families: Health Problems of Children.") To meet the complex needs of these children, the community must invest in programs of education, social welfare, and medical services, he maintains.

The first need of the parents in migrant farm families is for day-care centers at which they can leave their children during the long workday, says the author. The health provisions made in these centers depend on local needs, interests, availability of facilities, and professional services, he points out.

He concludes that a physician, working with the director of a day-care center for the children of migrants, a public health nurse, and lay volunteers, can make an indispensable contribution toward meeting the children's needs, by designating the tests to be made; planning and supervising an immunization program; suggesting ways of improving feeding habits; and drawing the community's attention to the long-range effects on children in migrant farm families of growing up in extreme poverty and ignorance.

photo credits

Frontispiece, Carl Purcell, National Education Association.

Pages 27 and 29, Tadder, Baltimore.

READERS' EXCHANGE

BRITTAIN: ***Start with the parent***

As Dr. Brittain's review indicates, investigators and clinicians working with the "culturally deprived child" struggle with the problem of providing the protective and pleasure enhancing values so often absent in a slum environment. ["Preschool Programs for Culturally Deprived Children," Clay V. Brittain, CHILDREN, July-August 1966.] Many believe that this can be accomplished in the classroom, but our clinical experience indicates that an educational program must be predicated on the values of the home to succeed.

In a psychoanalytically oriented study of nursery school children from an extremely low socioeconomic area, we found that a child, by association, will value what he knows or assumes is of value to the caretaking adult and ego-ideal. Thus, the primary effort must be to modify the value system of the culturally deprived home in consonance with the concept of a unified, integrated, and strong social order that emphasizes self-preservation and the preservation of a democratic society.

In addition to working with the values of the parent or parent surrogate, however, one must make him aware of the communication problems inherent in the child-parent relationship. What the child values is determined by his interpretation of parental values. Hence, the child must understand parental values as accurately as possible as these are modified.

We must also recognize the communication problem between the parent and the therapist. For example, the parents' affirmation that "education is good" may not mean what the educator may mean by that phrase. The mother of our nursery child might say, "If my child learns to read and write well, he can get a job that will pay him a better wage." We believe that education should improve the child's capacity for communication, interpersonal relationships, and better understanding with greater participation in community life.

Brittain's review of the studies of preschool enrichment programs seems to indicate that the focus on classroom activity failed to produce any significantly lasting results. We think that introducing a reorientation of values in the home regarding education and society is the most effective way of influencing the child to place value on the enrichment program and enable him to retain and use it.

Henry H. Fineberg, M.D.
Illinois State Pediatric Institute
Chicago

FINE: ***Some questions***

Regina V. Fine's article, "Moving Emotionally Disturbed Children from Institution to Foster Family" (CHILDREN, November–December 1966), is a sound contribution to the practice literature on the placement of children. She is careful to move children, not abruptly, but through sequential steps, smoothly combining old and new contacts; not arbitrarily, but with explanation and preparation; not as passive objects, but with encouragement to abreact their thoughts and feelings. Above all, Mrs. Fine refreshingly admits that she makes mistakes!

On another level of analysis—namely, the community planning level—I was troubled by the following:

1. Institutions decide to part with children. Why? Why can they not arrange living facilities under single administrative auspices?

2. In moving children who require therapy from an institution to a foster home, why is it necessary for the child to break off relationships with one therapist and form new relationships with another therapist?

3. A child runs away. The foster parents are ready to take the child back and work the problem through. Why does his running away become a reason for returning him to his former institutional placement?

4. Children who live in residential treatment institutions are apparently not geared to master life in normal families. Why not? Why can't this be built into the residential treatment institutional programs prior to replacement into foster homes?

These questions are troubling because they illustrate the degree to which societal and institutional procedures and constraints sometimes severely restrict the practitioner's flexibility in helping his client. It is time to recognize that institutional arrangements were not made in heaven, and that if children are to be helped, resources should be built around them, rather than the reverse.

Norman Herstein
Executive Director, Jewish Family and Children's Service
Boston, Mass.

A challenge to skill

To those of us who, like Regina V. Fine, have the task of helping emotionally disturbed children move from residential settings to foster family care, her article brings a statement of familiar problems that challenge our best diagnostic and treatment skill.

Her article not only describes a developing specialized function of agencies serving children, it also indicates the needs for greater sharing of information and better communication within the social work profession—as well as among the professions—in implementing the placement process.

Residential centers for the psychiatric treatment of emotionally disturbed children are finding that foster family care and group homes are necessary to the total therapeutic milieu. They enable the child to experience community living in a supervised, structured setting. This fact was recognized at the Children's Study Home in Springfield, Mass., soon after its reorganization into a residential treatment center for emotionally disturbed children 6 years ago. The Home, therefore, began recruiting foster families and small group homes. At present, the Study Home is serving 65 children: 15 in the residential center, 18 in foster family homes, 16 in small group homes, and 16 in the center's day-care program. The children in the day-care program, as well as some of the children in foster

families or group homes who need special educational assistance, attend the school operated by the agency at the residential center.

Through individual and group therapy programs for parents, we help parents maintain the strength to allow the children to remain in our program. We are now exploring the use of family diagnosis and therapy techniques. Mrs. Fine's article lends weight to the plea for exploration of new approaches. It is indeed gratifying to learn about what one agency is doing to revitalize a fundamental approach to the child who needs reconstructive experience.

Zeannette W. Lynch
Grace Spillane
Children's Study Home
Springfield, Mass.

WRIGHT: *Do we care enough?*

The introduction to Mattie K. Wright's lucid article, "Comprehensive Services for Adolescent Unwed Mothers," makes the old indictment that agencies fail to reach girls from the lower socioeconomic group. [CHILDREN, September–October 1966.] Granted, existing services *are* inadequate, chiefly because of lack of money, manpower, and a sense of *mission*. But for years, The Salvation Army has been reaching some of these girls. A study by Dr. Deborah Shapiro in three Salvation Army homes reported that the girls were "fairly heavily concentrated" in what is "upper lower class": 67 percent were white; 33 percent, Negro. Of the white girls, about one-third were from middle class families; two-thirds, from lower class. All but four Negro girls were from lower class families.

In Cleveland, for example, The Salvation Army is making a concerted effort through a day center with casework, group work, educational classes, medical care, vocational guidance, psychiatric consultation to take services to the people in their homes in the neighborhood. True this is just a "drop in the bucket" in relation to the needs, but it is *something*!

I hope Mrs. Wright's timely article will be read, studied, and acted upon by agency staffs and boards. It is studded with penetrating ideas which should move all of us to do more than we are now doing to reach more unmarried mothers, especially adolescents from low-income families.

I would like to underscore five ideas in the article: (1) *Concern* prompted the project; (2) the project is carried out through *collaboration* of health, education, welfare, and recreational services; (3) the project is located *close* to the people in need; (4) *criteria* are established for admission; (5) the demonstration project is being *continued* by a tie-in with local agencies.

At least three questions trouble me: (1) Do we need more research so that we can find more ways to give more help to girls like those in the 282 not accepted by the project? (2) Can we do more with unmarried fathers? (3) After the grants run out, what then?

Major Mary E. Verner
Women's Social Service Secretary
The Salvation Army Eastern Territory
New York City

MOSS: *Tunnel vision*

The article by Sidney Z. Moss, "How Children Feel About Being Placed Away From Home" [CHILDREN, July-August 1966], is valid in pointing out the necessity for helping children cope with their feelings about separation from their families if they are to use a placement experience in ways that will benefit them.

However, the article remains rooted to this factor, only one among many other important factors to which all child welfare workers must be sensitive. This too readily induces the type of tunnel vision that seriously limits a caseworker's helpfulness.

Many, probably most, of the children coming to care these days, whether to family or to a group care service, come as a result of complex family problems. Most of these children have previously been faced with separation, rejection, deprivation, and other traumatic experiences. Yet in his article, Mr. Moss states: ". . . when a child is placed in an institution, he faces two difficult adjustments: mastery of the separation trauma; and adaptation to the institution."

It is almost as though Mr. Moss believes that the children's first experience of crisis is the placement itself and that the goal of the caseworker is merely to help them adapt to a new environment. Elsewhere, Robert Lindner has aptly labeled this point of view as the "myth of adjustment." In point of fact, children usually arrive in placement with internalized feelings stemming from their past experiences, and increasingly their functioning in regard to these experiences is a significant factor behind their referral for placement. We must not have a stereotyped response.

For example, a teenage daughter of divorced parents was recently referred to our agency. The father had disappeared. The mother was trying to support her family alone. This child harbors death wishes for her mother and is defiant and unmanageable. Since the mother and daughter cannot resolve the difficulties in their relationship while they are so close to each other, the mother is now seeking placement as a means of providing the girl with the help she needs.

This child has already experienced the trauma of separation—from her father at age 11. In all likelihood this loss, having come at a critical time in her emotional development, is a salient factor in the emotional separation both mother and child are now experiencing. Which of the separation traumas would Mr. Moss elect for this girl to master first? That with father, with mother, or that which comes about again at the time of placement? There are several, and they need to be differentiated in the caseworker's understanding if the child is to be helped.

Elizabeth Lawder has pointed out in her article, "Can Long-time Foster Care Be Unfrozen?" [*Child Welfare*, April 1961], that there is *no* panacea to the problems of children in foster care today, that much of what inhibits the creative, purposeful, and productive use of placement as a treatment tool is the "rescue fantasy" phenomenon of professionals in the child welfare field, and that the growing body of knowledge about childhood could expand our understanding, influence practice, and ultimately lead to a differential concept of foster care.

Mr. Moss deals exhaustively with a part and, in so doing, lends weight to the "panacea approach." Unavoidably, the price paid for simple solutions to complex situations is poor service, for to deal with a part as though it were the whole is considerably less than the competent professional endeavor that is mandatory in seeking solutions to the problems of today's children.

F. Herbert Barnes
Executive Director, Carson Valley School, Flourtown, Pa.

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U.S. Government Publications

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GROWING UP POOR. Catherine S. Chilman. Department of Health, Education, and Welfare, Welfare Administration, Division of Research. WA Publication No. 13. May 1966. 117 pp. 45 cents.

This publication mainly reviews and analyzes research findings on child-rearing and family life patterns of very poor families in the United States today and the association of these patterns with mental health, educational achievement, social acceptability, moral character, and family stability. Includes suggestions for further research and for action programs.

CHILDBEARING IN AND BEFORE THE YEARS OF ADOLESCENCE. Roberta A. Savitz, M.D., Mary McCann, M.D., and Pauline G. Stitt, M.D. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 28 pp. Single copies free on request from the Bureau.

An annotated listing of material on early childbearing published between January 1960 and May 1965, classified under these topics: demographic considerations; cultural, physiologic, and psychologic tasks of adolescence; social and medical problems associated with childbearing; nutrition in adolescence and pregnancy; medical problems of offspring of adolescent mothers; and primary prevention of childbearing.

THE YOUTH WE HAVEN'T SERVED: a challenge to vocational education. Barbara H. Kemp. Department of Health, Education, and Welfare, Office of Education. OE–80038. 1966. 51 pp. 25 cents.

Describes ways in which vocational education programs can enhance their usefulness for young people who are handicapped socioeconomically and academically.

RESEARCH RELATING TO CHILDREN, Bulletin No. 19 (January–September 1965). Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 247 pp. $1.50.

An annotated listing of current or recently completed research projects reported to the Clearinghouse on Research in Child Life from January 1 through September 30, 1965. The studies are concerned with aspects of growth and development; the child in the family; social, economic, and cultural influences; educational factors and services; social services; and health services.

THE CARE OF YOUR CHILDREN'S TEETH. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 439. 1966. 12 pp. 15 cents.

A guide for parents pointing to the importance of diet and oral hygiene to the dental health of children, beginning with the eruption of the first teeth.

SUDDEN DEATH IN INFANTS: proceedings of the Conference on Causes of Sudden Death in Infants, September 1963, Seattle, Wash. Ralph J. Wedgwood, M.D., and Earl P. Benditt, M.D. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Child Health and Human Development, Bethesda, Md. PHS Publication No. 1412. 1966. 165 pp. $1.75 (paperback).

Includes eight papers and ensuing discussions on research findings and theories concerning the etiology of the sudden death syndrome in infancy, the verbatim report of a workshop on directions for future research, and a bibliography on published studies on the subject.

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